The First Schizophrenic Illness -

presentation and short term outcome,

incorporating a trial of prophylactic

neuroleptic maintenance therapy versus placebo

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Abstract

A multicentered study was conducted to investigate a sample of first episode schizophrenic patients. 253 cases satisfied criteria defining a first schizophrenic illness. They were characterised by their youth and the delay of weeks, months or years preceding admission. The cases were followed up for a maximum of two years after discharge from the first hospitalisation.

10.2% of the group of cases required prolonged inpatient care or extensive support in the community, 5% of the sample made a full recovery and were capable of academic or social achievements during the two year follow- up.

120 cases who achieved discharge from hospital participated in a double- blind study of maintenance neuroleptic therapy versus placebo as a prophylactic against relapse. The effect of active medication was very similar to that demonstrated in studies of schizophrenics who have suffered several episodes. Active medication proved superior to placebo as a prophylactic, and the more so in cases who had been ill for longer than one year. These latter patients were at a much greater risk of relapse than cases who achieved discharge from the first hospitalisation within one year of the onset of their illness.

82 cases participated in a study of the home environment. No relationship between highly emotional homes or extensive social contact with relatives and relapse was demonstrated.

I declare that I composed this manuscript myself, and that as a member of the scientific staff at the Clinical Research Centre, Harrow, I made a substantial contribution to the work.

In particular, I was responsible for the initial collection of cases, and interviewed 193 of the 215 families seen for sociodemographic data collection, completed 269 of the 352 standardised interviews with patients, was responsible for the conduct of the prophylactic drug trial and collected the information as to outcome for the 253 cases who were extensively examined.

Fiona Macmillan

The preliminary results of the prophylactic drug trial were presented in poster form, and the results of the home environment study present orally at the 14th Collegium Internationale Neuro-Psychopharmacoloquium, Florence, Italy, 1984.

1. Maintenance Neuroleptics and Relapse following First Schizophrenic Episodes. E.C. Johnstone, J.F.Macmillan, T.J. Crow and A.L. Johnson, Abstract No. P 793.

2. Expressed Emotion in Early Schizophrenia. J.F. Macmillan, A. Gold, E.C. Johnstone, T.J. Crow and A.L. Johnson, Abstract No. F-50.

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Dr Tim Crow suggested the idea of studying first episode patients, and I am also grateful to Mrs Aviva Gold who performed the interviews of families in the study of the home environment.

Patients and their relatives, at a time when they were faced with the personal sorrow of serious mental illness, assisted the investigator and continued to do so over months and years. I am in their debt, for the work, the manuscript and the experience.

CONTENTS

CHAPTER I

INTRODUCTION

The debate concerning the definition of schizophrenia and the prognostic implications of such a diagnosis has been unremitting since Eugene Bleuler introduced the term in 1911. E. Bleuler (1911) used "schizophrenia" to describe a particular mental state in which functions of the mind were split off from one another, and where the characteristic mental symptoms were not comprehensible in terms of the past life experiences and personality of the individual.

Kraepelin (1912) had already begun to differentiate forms of mental illness taking symptomatology, but also course and outcome into account. He grouped together illnesses characterised by symptoms based on changes of mood with a generally favourable outcome and contrasted this group of periodic mental illnesses with those in which psychological deterioration occurred in the great majority of cases. "Dementia praecox" was used by Morel (1860) to describe an illness with an onset in adolescence and a deteriorating course. Kraepelin suggested that dementia praecox was a distinct disease entity, despite its varied presentation, as the end states of dementia were similar to each other.

Despite this implication of a poor outlook Kraepelin described a small percentage of patients, who, having displayed the characteristic symptoms of the fragmentation of mental functions, had a favourable outcome, achieving lasting and complete remission. (These patients appearing to have the prospect of deterioration could not readily be placed with the group of periodic mental illnesses because of the nature of their mental symptoms.)

The separation of syndromes on the basis of psychopathology has

led to the search for symptoms diagnostic of schizophrenia. Whilst some classifications separate out groups of symptoms and designate them as central to the diagnosis of schizophrenia, particular symptoms are not powerful predictors of outcome for the individual patient. The diagnosis of schizophrenia thus remains with the probability of deterioration implied, but in presence of the possibility of complete recovery. The majority of patients do suffer some degree of deterioration of personality and function as a result of their illness.

Schizophrenia is primarily an illness arising in adolescence and early adulthood, although a proportion of patients develop such symptoms in late middle life. In the older group the prospect of personality deterioration is slight (Fish, 1978). The features of the mental state in an acute attack include disorders of perception, emotion, thinking, and disorder of motor behaviour (Fish, 1974). These arise in a state of clear consciousness in the absence of coarse brain disease. All forms of perceptual abnormality may be present, notably true hallucinations occurring in any sensory modality. Auditory hallucinations are common, in the form of hostile or complimentary voices. Such hallucinatory voices producing a running commentary upon the thoughts and actions of the patient are characteristic of schizophrenia, but the intensity and persistence of all hallucinations are variable. Visual hallucinations are correspondingly uncommon, while somatic sensations such as pain, heat, and cold, may be described by the patient, and often ascribed to the influence of outside agencies. Hallucinations of taste and smell also occur, and misperceptions of time and space may be described.

Disorders of thinking are present in schizophrenia and are demonstrated as disorders of the form, content or possession of thought. Lack of logical connection, seemingly random associations and incomprehensible speech are often present to a greater or lesser extent. A preoccupation with philosophical, religious or technological themes may extend to include grandiose or persecutory explanations of the patients' abnormal perceptions. The nature of prevalent themes may be a reflection of the individual's own interests or of popular topics of current political and sociological issues. Abnormal fixed beliefs that are not amenable to persuasion or contrary evidence and are out of keeping with the individual's social and educational background remain a hallmark of serious mental illness. Such delusions arising spontaneously may occur early in a schizophrenic illness, but no one set of delusional ideas is pathognomonic of schizophrenia.

Disorder of the experience of the self such as loss of possession of thought, emotion, or motor control are described as occurring in schizophrenia far more so than in other psychoses. The patient may experience alien thoughts penetrating his mind or describe penetration of his body by alien forces, and may feel his personality to be replaced by that of another force or being. Loss of emotional control, sudden tears and laughter for no reason may occur, sometimes in association with a diminution of emotional response towards previously important people and aspects of the patient's usual sphere of life. Anxiety, depression and perplexity frequently accompany these phenomena, but in the presence of grandiose religious delusions the patient may experience a state of ecstacy.

This wide range of abnormal mental phenomena may be associated with extraordinary behaviour, not infrequently of a life threatening kind. Patients may strike out at their imagined persecutors or respond to hallucinations and disorders of possession of the self with violence or senseless destruction. Some patients attempt suicide, overwhelmed by their experiences, or in response to altruistic motives based upon delusional conviction. Withdrawal from ordinary social intercourse may occur during the course of the illness, or prodromally before the patient becomes fully deluded or hallucinated. Withdrawal and decline in social function may be the predominant presenting feature in less common forms of schizophrenia and is a major part of the deterioration which is referred to as the defect state. Some patients become slow and hesitant, muteness may occur and abnormal postures maintained for prolonged periods.

The acute illness may present suddenly over hours, days or weeks, but a slow insidious onset over months or years is more common. Conflict with others arising from the preoccupations and behaviour of the individual may occur in the setting of an increasingly florid illness. It is not possible to ascertain how many individuals with such mental states function undisturbed and undisturbing in the community. Cultural factors are of relevance in the achievement of hospital contact and admission.

Thereafter the course and outcome of the illness varies widely. Extensive research has attempted to isolate clinical and social factors that have prognostic value for the acute attack and longer term outcome (Stephens, 1978). Follow-up studies conducted over decades have shown that the course is predominately a relapsing one, remissions generally but not invariably incomplete and there is a

tendency for the residual defects in personality and function to be found. A percentage of patients run a steady unremitting downhill course, a percentage may make a full recovery.

The introduction of phenothiazines in the fifth decade of this century was hailed as a turning point in the history of schizophrenia. These drugs appeared to hold the promise of a specific treatment (National Institute of Mental Health, 1964). Investigation of the pharmacological role of phenothiazines and allied neuroleptic drugs continues to expand, but their promise remains unfulfilled. There remain both a group of schizophrenic patients who respond poorly to these drugs, and those in whom apathy, withdrawal and the deterioration of the personality are not necessarily halted or improved by neuroleptic treatment (Letemendia, 1967). The development of depot neuroleptics aided a growing interest in the prophylaxis of acute attacks. The increasing use of long-term neuroleptic treatment over nearly three decades has demonstrated that such medication is not without hazard. The unwanted effects of acute administration include generalised increase in muscle tone and acute dystonic reactions (Ayd, 1961; Hall, 1956). Longterm administration has been implicated in the production of spontaneous involuntary movement disorders, most often of the face, but also of trunk and limb muscles (Crane, 1971). Such abnormalities have been described in schizophrenic patients before the phenothiazine era, (Kraepelin, 1912) but the contribution of medication to these sometimes irreversible changes remains open to question (Owens and Johnstone, 1980).

The purpose of this study was to examine a large cohort of patients receiving a schizophrenic diagnosis for the first time, in

their first psychotic episode. For a patient in that first episode of schizophrenia the acute management generally includes neuroleptic administration, but the case for prophylaxis is less clear. It was hoped that this study would provide information as to the overall benefit of neuroleptic maintenance treatment in this group; and give an opportunity to define samples of patients with poor and good outlook; and groups who would or would not receive benefit from longterm medication. It would also give an opportunity to compare the short term outcome in the post- phenothiazine era with the findings in the literature before 1950. More cohesive diagnostic schedules and the powerful, but not all powerful, treatment tool may have altered the outlook for these predominately young patients.

It was with these aims in mind that the collection, assessment and follow-up of the cohort was undertaken.

The Literature Review

Diagnostic and Research Tools, Selection and Presentations

Since Bleuler (1911) and Kraepelin (1912) began the debate upon concepts of schizophrenia, clinical diagnosis of the illness has remained dependent upon the chosen breadth of the concept. Delineations of the clinical picture are generally aided by qualifying clauses, such as Fish's definition of schizophrenia: "a group of mental disorders in which there is no coarse brain disease, in which many different clinical pictures can occur, in which the symptoms are not understandable nor arising from the mood of the patient" (Fish, 1978). Whilst most clinicians would concur with the view, even the concept of the syndrome as a mental disorder and the absence of coarse brain disease have been questioned.

Szasz (1974) dismissed the possibility of disease of the mind on the premise that the mind was not a part of the body and hence not subject to disease. Rosenham and colleagues (1979) reported the ease of acquiring a diagnosis of schizophrenia by assuming a single feigned experience of hearing an inexplicable noise. However a recent report by G.G. Hay (1983) suggests that where the clinician suspects the symptoms to be a feigned account of schizophrenia, (rather than the investigators clearly and deliberately misleading the clinicians) the passage of time leads to substantiation of the diagnosis. Arguments such as these of Szasz and Rosenham, whilst aimed at denying the existence of mental disorder, are perhaps more suitably considered as demonstrations of the problems of clinical diagnosis.

H. Gillies (1958) described in an elegant monograph the suspicion

of early schizophrenia being raised by bewildered or inappropriate emotional responses in young patients, before the presence of clear delusional mental content may be demonstrated. Bleuler (1911) described hallucinations and delusions as being secondary to the primary disorders of schizophrenia, such as disorder of thinking with vagueness and illogicality, and disorders of volition and drive, and impaired emotional responses with withdrawal. In clinical practice it is most commonly clear delusions or hallucinations or both that indicate the presence of a psychotic illness, and consideration of a schizophrenic diagnosis.

The requirement for the absence of coarse brain disease leads to the requirement that the patient have full orientation and a clear consciousness. In the presence of gross disorders of thinking, it may be hazardous to establish the orientation of a patient with reference to time, place and person. The International Classification of Diseases (World Health Organization, 1978) in the section dealing with functional psychotic illness makes reference to mild disorientation in the subclassification of schizophrenia, perhaps in part to account for the difficulty of establishing a patient's orientation. There is increasing evidence that abnormalities of the central nervous system may be associated with schizophrenia. The finding of enlargement of the lateral ventricles in the cerebral ventricular system was first reported by Jacobi in 1927, and advances in imaging techniques have increased the literature dramatically in the last decade. Most commonly these abnormalities have been demonstrated in cases where severe schizophrenia has been present for many years, or decades, but such abnormalities have been reported to relate to poor response to

treatment (Weinberger 1979, 1980). Kraepelin and Bleuler, whilst emphasising the absence of coarse brain disease, made references to the probability of underlying neuropathological changes.

The relationship between coarse brain disease and schizophrenia has been examined in epileptics by Slater (1963) and in other conditons such as cerebral syphilis by Froshaug and Ytrehus (1956). Both organic conditions have coexisted with psychoses indistinguishable on clinical grounds from schizophrenia. Epilepsy and schizophrenia are thought to coexist more often than by mere chance, and cerebral syphilis is widely accepted as having a causal role in the genesis of schizophrenic-like illnesses. Davidson and Bagley (1969) have reviewed the literature on the topic of organic disease and functional psychoses. The absence of coarse brain disease as a prerequisite for a diagnosis of schizophrenia to be made may be dependent upon the ability or otherwise to clearly demonstrate disorders of the central nervous system.

These difficulties are separate issues from that of the breadth of the concept of the illness that is adopted. Some clinicians will make a diagnosis only if definite evidence of deterioration of the personality is available, which to some extent requires that outcome is established before a diagnosis is made. Others will act upon the idea that 'even a trace of schizophrenia is schizophrenia' (Lewis and Piotrowski, 1954). Diagnostic practice may further reflect therapeutic optimism. Baldessarini (1970) examined the fluctuation of diagnostic practise over some decades at an American psychiatric centre. An increase in the use of 'schizophrenia' arose coincident with the introduction of phenothiazines, a 'specific' treatment for schizophrenia. Later a rise in affective diagnoses

occurred when Lithium Salts were introduced as a prophylactic treatment for manic depressive psychoses.

The separation between affective and schizophrenic psychosis was formulated in part upon the different outcomes associated with these two illnesses, and in part upon symptomatology. Schneider in 1959 (1959) described a set of particular symptoms, believing these mental phenomena to be found in schizophrenia alone. Studies of the value of these symptoms such as by Mellor (1982) indicate that whilst they are often present in schizophrenia, between 28 and 78 percent of cases having these first rank symptoms, they are not invariably absent in affective or even neurotic disorders.

Kendell (1975) has described the relatively robust nature of a broad diagnostic category such as schizophrenia, and Norris (1959) demonstrated the consistent nature of the diagnosis within London, with about 70% agreement in diagnosis between local hospitals. Revision of the diagnosis was reported by Dunham (1965) to occur at about a level of 10% or less in cases of schizophrenia, and Copeland (1971) extended the views of Norris to suggest that diagnostic practice across Britain provides fair agreement as to what may be considered schizophrenia.

In this study the initial referal of cases was dependent upon a clinical diagnosis of schizophrenia, and it was hoped that referral would occur early in the admission. The use of a clinical diagnosis as a first step in the selection of cases was considered preferable to examination of all new admissions, as the yield of schizophrenic patients would be low. Amongst first admissions some 16 percent may be schizophrenic (ref. Strauss, 1978) Inevitably early clinical diagnosis may include organic and affectively ill patients and the

pattern of referral would reflect the concept of schizophrenia held by individual clinicians participating in the study.

Research criteria for defining schizophrenia and other mental illness has now become an extensive subject, stimulated by cross national and international studies (Cooper, 1972). The search for the best diagnostic research criteria remains as problematic as clinical diagnosis. The stringent diagnostic criteria for schizophrenia such as the Feighner criteria (Feighner, 1972), in which clear deterioration or illness of at least six months duration is a pre-requisite, may be contrasted with the Newhaven Index (Astrachan, 1972), devised to include brief illnesses with a good recovery. Application of research criteria may tend to select overlapping groups of patients (Brockington, 1978) or very small groups of patients (Taylor, 1978). Where a study involves the examination of an intervention, such as a form of treatment, the choice of research criteria may have major effects upon the results. Rigid selection on Kraepelinian lines of cases in whom deterioration and a very poor outcome is likely may yield a group of patients whose illness is relatively unresponsive to intervention (Stephens, 1978). Inclusion of the most mildly ill and a very wide definition of schizophrenia, may produce a sample where spontaneous remission can obscure the effects of intervention (Leff, 1973). The intervention in this study was of prophylactic medication against relapse of the schizophrenic illness. With the inherent difficulty of making a clinical diagnosis of schizophrenia at a first presentation, the Present State Examination (Wing, Cooper and Sartorius, 1974) was selected as a method of defining the symptomatology in detail and for providing a research diagnosis.

This research tool gives an assessment of the range of symptoms, but only a limited account of severity, and details symptoms present for any part of the month preceding the examination. Thus duration of symptomatology is largely neglected. It is reliable and well recognised from international studies, (World Health Organization, International Pilot Study of Schizophrenia, 1973) and was considered appropriate for use in the multi-racial setting of North London, Hertfordshire and Bedfordshire.

This study was based upon hospital admission. While differing diagnostic practice has led to international differences in the use of the term schizophrenia (Stephens, 1970) there is a degree of stability in examination of samples of schizophrenics presenting for the first time. Dunham suggested that epidemiological investigation of schizophrenia can realistically be based on hospital statistics, on the basis of his examination of schizophrenics making psychiatric contact for the first time in 1958 (Dunham, 1965). He included any case where the diagnosis was made on clinical grounds at any medical agency, but found that 87.3% of the schizophrenics were diagnosed at hospital contact as opposed to any other medical agency. Comparing these schizophrenic cases with other mental illnesses he found the schizophrenics more likely to have made multiple contacts with agencies, and over one third to have contacted more than one medical agency. These cases were roughly evenly divided by sex, and aged predominantly between twenty and fortynine years old. Dunham comments that delay in hospitalisation was common and that outpatient management without a period of hospitalisation uncommon.

The Table below lists similar information concerning the age of onset or admission, and the distribution of sex in studies of first episodes of schizophrenia from 1900 to 1968.

Name	Year of Sample and nature	No Cases Sex	Details	
Lindelius	1900-1910	237	Age 1st Illness	Delay
1970	prospective	104M/133F	27.1M	46% <1yr
	1st attack		32.3F	54% >1yr
	schizophrenia			
Israel	1913-1954	4254	Age	
and	1st admissions	2052M	20-34 55%M	
Johnson	for schizophrenia	2202F	20-34 49%F	
1955	1913-23	456	Age onset retrospective	
Rennie	voluntary adm.	224M	21-30 51.1%	
1939	diagnosed sch.	276F	delay days - 12 years: mean 13.5 mth	
Freyhan	1920-1940	100	peak 25-30	
1955	consecutive	100		
	admissions	M=F		
	(retrospective)			
	schizophrenia			
Froshaug	1933-5	95	(1933) 32.6 yrs	Delay
and	+1953-59	103	(1953) 37.4 yrs	1933 2.1 yr
Ytrehus	1st admission to	F	mean at admission	1953 3.1 yr
1963	centre, females,			
	schizophrenics			

Name	Year of Sample and nature	No Cases Sex	Details
Holmboe and Astrup 1957	1938-50 All 1st admission illness <6/!2 schizophrenics selected	255 132M/123F	Age at onset % cases < 20 9.4 21-30 35.3 31-40 36.8 > 40 18.4
Huber 1975	1945-49 consecutive 1st admissions diagnosis psychosis	502 2M/3F	Age % cases < 19 24.5 20-29 37.0 30-39 24.5 > 40 13.9
Hallgren and Sjogren 1959	*born in 1900 case note selected schizophrenia	247 schizophrenics and mental defectives	Age of onset (schiz only) male 28.0 +0.7 female 32.2 +0.9 delay 58% < 2 yrs 38% < 1 yr
Bleuler M. 1978	**1942-43 schizophrenia	selected 1st admissions 68 cases	Age at 1st admission % < 19 7.3 20-29 30.9 30-39 32.3 > 40 29.4

* selected by date of birth

** 1st admissions selected from total population of 200 cases

Cooper 1961	1949-53	224 males	Age at 1st admission 32.7 yrs 27% admitted by authorised officer

Name	Year of Sample and nature	No Cases Sex	Details
Achte 1967	1950 1960 1st admission Schizophrenia or paranoid psychoses	200 72M/128F	delay 1950 10-11 mths 1960 12-16 mths Age by sex from Lewine from Achte %M %F < 20 18.5 7.9 21-30 53.7 28.7 31-40 18.5 28.7 > 41 22.1 34.6
Bland 1976	1963 1st episodes of schizophrenia from case notes [selected sample some 1st contact]	79 43M/36F	Age < 20 11.6 5.5 20-29 32.6 30.5 30-39 34.9 30.5 > 40 20.9 33.3
Nyman & Jonsson 1983	1964-67 consecutive 1st admission schizophrenia	110 72M/38F	Age (retrospective) Delay onset 19.1 yr 82% > 1yr admission 25.9 yrs
Forrest and Hay 1972	1966-68 admissions for (not 1st) schizophrenia	375 177M/198F	Age 1st admission retrospective %M %F < 20 15 6 20-29 45 32 30-39 21 30.5 > 40 19 31.5

These studies were either deliberately constructed to find first admission schizophrenics, or included substantial subsamples of first admission cases. They are tabulated by the year of collection of the sample, with only Hallgren and Sjogren collecting a sample based on date of birth rather than at the point of admission. Froshaug and Ytrehus collected only female patients, Cooper only males, other samples are of both. Where reported there are fairly consistent findings with reference to age of admission, age of onset and sex. Characteristically females are older than males, and both males and females are admitted predominantly in youth some months or years after onset. Rennie reports a period between onset of the illness and admission ranging from days to even a decade, with a peak period of over one year, in a sample collected between 1913 and 1923. Lewin analysed Achte's data and found that the period between onset and admission had a mean of two years, in 1950 and 1960, and further analysed Strauss's first admission data (Strauss, 1978) to find similar age/sex differences in respect to schizophrenia (Lewin 1980, 1981). Nyman and Jonsson report that 82% of their sample had a year or more of illness predating admission, in a sample collected in 1964 to 1967.

Forrest and Hay collected a group of 375 cases admitted with a diagnosis of schizophrenia between 1966 and 1968, and retrospectively estimated the age at the first admission for schizophrenia. Holmboe and Astrup collected 255 acutely schizophrenic cases with no more than six months illness prior to the first admission. The distribution of age at onset of these cases collected between 1938 and 1950 bears comparison.

Forrest and Hay (1972)		Holmboe and Astrup (1957)	
Retrospective age of 1st admission		1938-50 1st admission	
Age	%	Age	%
20	9.0	19	10
21-30	35.0	20-29	38
31-40	37.0	30-39	26
40	19.0	40	26
all cases		all cases	

The diagnostic practice involved in these studies ranged from the unspecified application of schizophrenia by any clinician (Dunham) across case note diagnosis confirmed by case note examination by the author (Lindelius) to the adaption of a narrow definition of schizophrenia with stress laid upon course as well as symptoms (Hallgren and Sjogren). Despite the range of definitions the samples bear resemblance in the simple terms of age of onset and admission, and the differences in age between males and females as presented.

The mode of admission is reported as voluntary by Rennie (1939), and simply as first admissions for schizophrenia in the other studies, Cooper noting the excess of involuntary admissions in the lower social classes in his study of 224 males. Details of admission procedures are reported by Froshaug for the sample collected between 1953 and 1959, and by Achte for a similar time of collection in 1950 and 1960. The mode of admission may reflect medical and hospital policy, accessibility of services and the degree of social disturbance displayed by the patient population, which may be more or less related to the mental state. Admission to hospital is not a simple correlate of the mental state, nor to the

quality of social disturbance caused and suffered by the patient. Strauss (1978) examined first admission patients, finding an excess of low social class in many diagnostic groups. Goldberg and Morrison (1963) had found fathers of first admission male schizophrenics to come from social classes representative of the general population, indicating that there was a downward social drift of the patients. In cross cultural studies the presence of psychiatric illness similar to schizophrenia in societies where industrialisation is not applicable have been found (Murphy, 1976). In an examination of the Hutterites (Eaton, 1955), a particular sect renowned for their lack of use or apparent need of psychiatric services, psychotic illnesses were found. These were very predominantly depressive with a relative paucity of schizophrenia, although details of the mental state of the cases are not given. The investigator noted the relative absence of social disturbance in the society, and the lack of use of medical facilities may be in part a reflection of this, rather than of the absence of illness. Dunham asserted that most schizophrenics were eventually hospitalised, and Helgason (1964) found in an epidemiological study in Iceland that some 17% of schizophrenics did not receive inpatient care. The general pattern of a delay between onset and admission of months or years recurs in the literature, with evidence of admission being achieved less frequently by the patient alone. Dunham noted that of his schizophrenic sample 33% made contact with 2 or more services, some 10% were in contact with 3 services and some 2% with 6 or more services. Achte noted the proportion of cases admitted voluntarily and the proportion legally detained in his sample of first schizophrenic patients. In 1950, 88 cases were admitted voluntarily

and 34 involuntarily, the proportions in 1960 being little changed at 74 cases and 27 cases. This may be distorted as Achte describes the tendency to detain patients legally as a precautionary measure. However in 1950, 34 cases were brought to hospital by the police, and 27 in 1960. Achte does not inform as to whether these were the same cases as were detained legally. Strauss (1978) reported that 2 of the 38 cases of first admissions who were diagnosed as schizophrenia came to admission following suicidal bids. He noted the generalised reduction in social functioning, most especially in terms of employment, which occurred in the months preceding admission in all psychiatric cases, including the schizophrenics. Froshaug and Ytrehus noted the route of admission of the 103 female patients admitted from 1953 to 1959. In 18.4% of these cases admission was sought by the patient, in 1% it was not known, and in 80.5% of cases admission was sought by people other than the patient, such as relatives, employers and police.

The literature concerning the disturbance in the community associated with schizophrenia is often designed to look at major crime, usually in diagnosed cases of schizophrenia, but also at the effect upon the family. Creer and Wing (1974) in a monograph examining the burden that caring for a schizophrenic relative imposes upon a family made reference to the "difficulties in obtaining help at the very beginning", a common complaint of relatives. These relatives approached family practitioner services and social service departments to little avail and "eventually the disaster they had foreseen occurred ... the son committed a sexual assault and was finally compulsorily admitted to hospital". Both aspects of the illness are considered within Outcome and Prognosis

in the Review.

In summary, whilst the clinical diagnosis of schizophrenia remains difficult and ill-defined, and no sure and certain research criteria exist, the diagnosis made at hospital contact has a degree of consistency over time and across geographical areas. Such patients are characterised by their youth, the delay between onset and admission is usual and admission is more commonly instigated by persons other than the patient.

The Outcome and Prognosis of Schizophrenia

Knowledge of the outcome of schizophrenia is required to define and to assess factors of prognostic importance. It is well recognised that the outcome spans a wide range and may fluctuate over time, so that assessment of outcome at two years may be different from that at five (Achte, 1967). Stephens (1978) reviewed four decades of literature concerned with the longterm outcome of schizophrenia and drew attention to the influence of selection of the cases upon outcome. He found more cases where outcome was poor in studies which used a Kraepelinian concept of schizophrenia for selection, as opposed to studies employing a wider diagnosis. He suggests that measures of outcome applied at a single point in time have the disadvantage of failing to demonstrate fluctuations in the illness. Figures for schizophrenia recovered and permanently hospitalised, derived from the study of five hundred patients with functional psychoses, show changes for the first few years, tending to level out at five to ten years (Morrison, 1973).

		Time in years from index admission				
		0-1/2	1	2-3	5	10
200 schizophrenic cases	% recovered	0	3	12	14	19
	% still in hosp.	40	39	26	20	19

However, M. Bleuler (1978) described cases who, after two or three decades of illness, showed improvement in their mental functioning.

Methods of assessing outcome have altered, perhaps in response to the increasing numbers of schizophrenic patients who achieve discharge. Guttmann, Mayer Gross and Slater (1939) examined patients three years after an index schizophrenic illness in 1934 and found 41.2% of the cases to be 'hospital invalids' and their classification by outcome included hospitalisation, with and without periods of remission. The fall in those continuously hospitalised from 60% in the 1930's to 10% in the late 1950's (Brown, Parkes and Wing, 1961) in the United Kingdom is echoed elsewhere. Froshaug and Ytrehus (1963) recorded the mean duration of a first admission for schizophrenia to be 71.5 months in 1933 and only 8.5 months in 1953, in their Swedish sample. This fall in the initial duration of hospitalisation and the reduction in numbers who require hospitalisation for years predates the introduction of phenothiazines. The practice of early discharge and rehabilitation may reflect changing attitudes to the mentally ill. However M. Bleuler draws attention to the relative infrequency of cases suffering unremitting deteriorating schizophrenia, resistive to any intervention presenting after 1940. Estimates of recovery are subject to a wide variation, Lindelius (1970) reporting 12% of patients recovered, without a defect, with a follow-up ranging from one to twenty years. These cases were followed where possible

till death, and he reports an excess of death due to tuberculosis, mostly but not exclusively within the chronically hospitalised group. 78% of the deaths in those aged under 60 were due to tuberculosis in his sample. Holmboe and Astrup (1957) selected their first illness cases as having less than six months illness at admission, and 29% of their sample were relapse free and recovered at follow-up from six to eighteen years later. No account of deaths or suicides are forthcoming and interpretation of this figure is not easy, but the major classification of outcome describes deterioration either at home or in public care; improvement, and recovery with and without relapse. Achte (1967) includes death, in which suicide occurs in 1-5% of the sample at five year follow-up, and distinguishes between social recovery and discharge to unemployment. He classifies 30% of the sample of 200 cases as recovered, from admission in 1950 and 1960, at two year follow-up.

The increasing discharge rates became coupled with the use of neuroleptic medication as both an acute and a prophylactic treatment, and measures of outcome have subsequently had to contend not only with prognosis but also with drug responsivity. The collaborative study of the National Institute for Mental Health demonstrated in 1961 the superiority of neuroleptic treatment in acute schizophrenia, compared with placebo in a double blind study (NIMH, 1961). It also demonstrated that improvement on placebo does occur, and 23% of the placebo treated patients achieved 'substantial improvement', as opposed to 73% of those on active neuroleptic drugs. One hundred and nineteen cases were withdrawn from the study, for a variety of reasons, including ten cases who made an early spontaneous remission. The one patient from the latter group

who was receiving placebo treatment is a reminder of the widespread clinical experience of remission prior to the phenothiazine era.

The clinical expectation of the acute effect of neuroleptics was confirmed by clinical trials, such confirmation was not forthcoming for insulin coma therapy (Ackner, 1957) despite the initial enthusiasm for the physical treatment. Later studies of neuroleptics suggested that their major effect was to diminish hallucinations, delusions and incoherence of speech, and to improve the incongruous affective response of the patient. However poverty of speech and flattening of emotional responses have not been found to be primarily responsive to neuroleptic treatment (Johnstone and Crow, 1978). The evidence for a prophylactic effect by continuing treatment beyond the stage of diminution or ablation of hallucinations and other positive psychotic symptoms is overwhelming. Davis (1975) reviewed twentyfour well controlled clinical trials and described a degree of agreement in the results that is rarely found in psychiatric research. These studies conducted in the 1960's and 1970's give overall relapse rates of 65% on placebo and 30% on active neuroleptic treatment. The evidence that some cases remain relapse free without the aid of longterm medication is also very clear, and studies such as those of Hogarty and colleagues (1974ii) and Leff and Wing (1971) indicate that 15 to 20% of cases may remain well for two years or more, on placebo alone. Johnson has examined cases maintained on neuroleptics for many years and describes relapse occurring upon withdrawal from active medication, not apparently reduced by many years of relative well being (Johnson D.A.W., 1979).

The paradoxical situation remains that whilst neuroleptics are

the acute and prophylactic treatment of choice in schizophrenia, few clinicians would advocate such treatment for every schizophrenic. Outcome studies have thus shifted in emphasis from chronic hospitalisation to examination of relapse and readmission; also examining social and occupational functioning. Schwartz (1975) examined one hundred and thirtytwo schizophrenic patients some two to three years after an index admission, which for one third of this sample was a first episode of illness. He used separate measures at follow-up to evaluate psychiatric mental state, economic productivity, social functioning, and noted readmissions which had occurred in the follow-up period. The level of social and economic function at follow-up was better in those patients with a less morbid mental state, but sociodemographic variables such as the educational attainments of the patients were related to these aspects of function at follow- up. The occurrence of rehospitalisation during the intervening two or three years did not relate to the mental state of the cases at follow-up, and bore a relationship only to the use of prophylactic medication. Enquiry was made about the satisfaction the patient and family felt about the care from medical and other services. Where the patient had experienced social decline satisfaction was low, but was increased in response to the amount of contact that had occurred with the caring services. Schwartz also noted that for his sample, very brief initial hospitalisation of only a few days was likely to be followed by rehospitalisation. This concurs with Dunham's view that outpatient management without hospitalisation is not frequently successful in schizophrenia. The Schwartz study emphasises the need for multiple assessment of outcome and the need to relate the status

of the cases to their social and economic background. Cooper examined social class in relation to the initial presentation of 224 male schizophrenics admitted for the first time between 1949 and 1953. He relates a briefer duration of hospitalisation and less chance of permanent hospitalisation to the higher social classes. In his subsequent paper examining the outcome after discharge he relates return to employment and higher social class to a more favourable outlook. Although Cooper feels that these relationships between higher social class and a better outlook indicate that socioeconomic stress may be a factor in the genesis of schizophrenia, he makes no account for delay in treatment being involved, other than that which he feels to be linked to a lower socioeconomic status. Two recent studies of outcome of first episodes of schizophrenia (Bland, 1976; Nyman and Jonsson, 1983) used multiple assessments but yielded somewhat discrepant results. The results are tabulated for comparison.

TABLE: details from:

Bland 1976 wide diagnosis/rediagnosed cases excluded

Nyman 1983 wide diagnosis/schizoaffective cases excluded

Variable		Bland	Nyman
cases		92	110
sex M/F		1.2/1	1.9/1
follow-up		10-12 yrs	6-9 yrs
Age mean at admission		34	25.9
Marital Status			
at admission	single	51.1%	88%
Follow-up			
rehospitalised%	none	36.4	19.0
	once	17.0	15.5
	twice	21.6	14.5
	>twice	25.0	41.8
	permanent care	8.0	8.0
Employment			
% lost time		28%	40%
Marital at follow-up		43.2% (12 in F/up)	28% (8 in F/up)
children		32 from 16 cases	10 from 7 cases
Death %		13.6	14.0
Suicide %		2.3	7.3
Good outcome		58%	27%
Best outcome		-	7%

Both groups of investigators used wide diagnostic methods that did not require absolutely that deterioration was present, and while Bland excluded cases that had had a different diagnosis

substantiated in follow-up, Nyman excluded schizoaffective cases. The Canadian cases investigated by Bland are older, contain more females, and more are married than the Swedish population of Nyman. The difference in number of married patients is probably explained by the sex ratio and the age group, female schizophrenics being more likely to marry and very youthful sample likely to be single. Given these differences both groups report 8% of cases to be receiving institutional care, and in both groups small numbers (12 and 8 respectively) marry during follow-up and children (32 and 10) are born. Bland describes the marriage rate as lower than that of the general population, the divorce rate to be higher, and the occurrence of childbirth to be very similar to the general population. The length of follow-up is a decade or more by Bland, and some six to nine years for Nyman, but both groups report death occurring in small numbers (13.6% and 14.0% respectively). The deaths due to tuberculosis reported by Lindelius (1970) have receded, but suicide is a cause of death (2.3% Bland 1976; 7.3% Nyman 1983). Where small numbers are available and the reporting of suicide may be uncertain (one case of Bland's died by aspiration, another in hepatic coma, but no details are given of these events) these figures may be comparable with Achte's data of 1-5% death by suicide at five years (Achte, 1967). The discrepancy between these studies lie largely in rehospitalisation and in assessment of 'good outcome'. Although Bland describes 58% of his sample as having no social or intellectual deficit, only 36.4% of the sample have avoided rehospitalisation, thus demonstrating the apparent difference in outcome when an assessment of a point in time is compared with a variable assessed over the passage of time. Nyman

describes 27% of his sample as having a good outcome, but only 19% remain readmission free, and he notes that when the most stringent criteria are adopted and those with very minimal defects are excluded he can class 7% of his cases as being of the very best outcome. Whilst Bland describes one third of his sample as not receiving psychiatric or medical follow-up and half the sample as out of contact with services for the last two years of follow- up, Nyman notes that 2 of his 13 cases who did not come to rehospitalisation were chronically psychotic throughout the period of follow-up.

From outcome studies similar to these, prognostic factors have been examined, but the differing criteria used to assess outcome in groups of patients of mixed duration of illness may confound the study of these very factors. Past performance tends to predict future outcome, and where diagnostic criteria which incorporate chronicity are used, outcome is generally poor (Stephens, 1970). Two approaches to the isolation of prognostic factors are commonly employed. Assessment of outcome may be dichotomised into relatively good and relatively poor outcome, and variables collected at an index presentation examined within the dichotomised outcome groups. Alternatively cases of known good outcome may be collected and the past presentation examined in the hope of finding a common good prognostic factor. Prognostic factors have been sought within the mental state, notably in terms of the presence of affective symptoms of consistent depression or elation, or the affective response, in terms of flattening of affect; and within sociodemographic variables such as sex and social class, and in terms of the nature of the presentation and the duration of presenting illness.

Within the mental state consistent change in mood has been thought to be of good prognostic significance (Valliant, 1962; Taylor, 1972), but recent studies by Carpenter (1978) and others (Gift, 1980) in association with the International Pilot Study of Schizophrenia have failed to replicate this finding. Carpenter (1978) divided his population into good, medium and poor outcome, and using the good and poor outcome groups analysed the signs and symptoms presenting five years before outcome was assessed. Consistent change in mood, such as depression, did not bear an association with outcome, but restriction of affect was associated with a poor outcome. Valliant (1963) reviewed the literature concerning manic depressive heredity in schizophrenics, and concluded that a manic depressive heredity was a favourable prognostic indicator where there was a clear absence of a family history of schizophrenia. In a later study (Valliant, 1978) he collected a cohort of 51 remitted schizophrenic patients and re-examined them, to find that remission was sustained over a follow-up of 4 to 16 years in 31 patients, and relapse occurred in 20. Examination of the first illness for affective change demonstrated no difference between those sustaining remission and those relapsing, but the initial remission did appear related to the presence of consistent affective change. Thus as described in earlier literature early and late outcome may be very much at variance. Valliant (1978) described the presence of confusion at first admission to be equally distributed in the 51 cases of remitting schizophrenics he followed-up, and the limited value he ascribes to the presence of confusion and affective symptoms as longterm prognosticators is supported by Welner's study of

schizoaffective patients and studies of first admission schizophrenics by Bland and by Gift (Welner, 1977; Bland 1976; Gift 1980).

The presence of flattening of affect as a prognostic index of poor outcome remains supported by the literature. Both Stephens (1970) and Vaillant (1962) have drawn attention to this and other factors of prognostic impact. Features drawn from areas other than the mental state tend to reflect the quality of outcome in their associated areas. Hence subsequent employment is linked to past work performance and subsequent hospitalisation to past use of hospitalisation. These factors might be considered as descriptions of the most able and least able individuals, suffering from the most serious or least serious forms of illness. Cases of adequate intelligence who have a good work record and have married, or, have other evidence of a good personality and adjustment (such as displaying no traits of withdrawal and isolation), fare relatively better from schizophrenia than those not so advantaged. An acute onset in the face of precipitating factors is a prognostically favourable presentation, as is a preserved affective response in the face of the illness. The symptoms of alteration of mood and confusion and the evidence for the favourable effect of a family history of affective illness has led to the consideration of a group of patients who suffer illness intermediate between manic depressive and schizophrenic in nature. Vaillant (1978) asserts that there are simply some schizophrenic patients who do recover and stay well, as noted by Kraepelin and by Bleuler.

It is difficult to separate out the sociodemographic variables which define premorbid function in educational, occupational and

social terms, from factors associated with the onset of the illness. Insidious onset and a protracted period of ill-health prior to hospitalisation are common. During this period the opportunity to attain educationally, to be employed and to marry, may be affected by the illness, and the separation of premorbid function from the nature of onset is excessively difficult. Older patients tend to have better outcomes (Moller, 1982), perhaps because they have not suffered impaired function during the determinant years of early adulthood. Gelperin in 1939 described spontaneous remission in schizophrenia, relating this event to the duration of symptoms. The outcome of these cases in terms of spontaneous remission is related to the total duration of symptoms preceeding admission with a follow-up period of about 4 years. The Table drawn from his study (below) leads Gelperin to conclude that patients who enter hospital soon after the onset of their symptoms have a better prognosis than those who enter late, and that this factor is not necessarily related to treatment. Although it is not clear how the diagnosis of schizophrenia is made Gelperin states that outcome was not used in making the diagnosis.

Table from Gelperin 1939

Duration of symptoms prior to admission months	No of Cases	% Improved	Average duration of hospital stay in improved cases
0-6	103	51.4	5.4
8-24	30	30.0	8.9
24+	90	30.0	12.9
Unknown	12	41.6	4.0
Total	235	40.0	7.7

It is possible that this group contained cases which would now be considered to be suffering from affective illness. Lindelius (1970) echoes the findings of a rapid entry to hospital being linked to a briefer duration of stay and a better outlook.

Table from Lindelius (1970)

	Outcome % by duration symptoms					
Duration of symptoms prior to admission months	well	Recovery social recovery	mod/severe defect	Died in hospital	Not discharged	Total
0-3	44	18	18	20		100
3-24	9	16	15	57	3	100
>24	1	8	29	62		100
Nos of cases	31	31	50	122	3	237

Spontaneous remission leading to discharge has been supplemented by changing policies of hospital care, and Bland (1978) expresses the view that the improved outlook for schizophrenics may

be the result of the use of neuroleptic drugs as well as policies of briefer hospitalisation with the widespread use of community based resources. Readmission seems most clearly related to the use of prophylactic neuroleptic drugs, but it is not clear whether or not these drugs have benefits other than diminution of the florid symptoms of the illness and in relapse rates.

Rappaport (1978) suggests that some patients without any neuroleptic treatment not only remain relapse free for up to three years, but also show less pathology and less disturbance in the community than those receiving acute treatment but no prophylaxis. These views he confines to a specially selected group of male patients and when attempts were made to control for those cases who were not available for follow-up the effect of acute treatment upon the function at three years is lost. Pritchard (1967 i, ii) examined the effect of acute administration of phenothiazines comparing fifty schizophrenics treated before and fifty treated after the introduction of these drugs. 76% of his sample are first admissions. At a three year follow- up he assessed subsequent hospitalisations and found no clear evidence for the long term benefit of acute treatment in these terms. He concludes that the benefit of treatment in terms of duration of hospitalisation is largely applicable to those who might have had a poorer prognosis.

Astrup and Noreik (1962) have suggested that drug treatment may delay or prevent the development of a defect state, whilst Strauss (1974) has suggested that minimal use of neuroleptics (range 200-600 mg chlorpromazine) is linked to a better global evaluation of outcome at one year, where work, social function, symptomatology and subsequent hospitalisation are used to make the global assessment.

Longer term studies examining follow-up for 5 years by Bourgeois and Marvaud (1968), and Bockoven and Soloman (1975) suggest that there are no powerful differences in outcome before and after the introduction of neuroleptics. The conflicting views of the role of phenothiazines are reminiscent of the differences found in the results of other outcome studies (Nyman and Jonsson and Bland), where the definitions of outcome and their mode of assessment produces variations of the theme of a wide range of outlook, from total recovery to chronic incapacity.

Suicide is an event associated with serious mental illness and estimates vary from 1 to 10 per cent in schizophrenics over variable periods of follow- up. Tsuang (1980 i) demonstrated a reduction of life expectancy in schizophrenics of a decade for males and nine years for females, compared with age and sex matched life expectancy from the general population. The excess of death was due largely to suicide and accident (Tsuang, 1980 ii). The population was followed for two or three decades, but Wilkinson (1982) found 3 out of 39 cases of first episode schizophrenics to have committed suicide in a case note follow-up over ten to fifteen years. Nyman and Johnson, and Bland estimate suicide as 7.3% and 2.3% at nine and twelve years respectively. Planansky (1971) examined suicidal acts, threats and thoughts in 205 schizophrenic patients, who were consecutively admitted. Acts based on suicidal ideas occurred in 25% and thoughts of suicide were present in 40%. He reported from the same sample the presence of homicidal thoughts and acts, and found that 21% of the 48 first admissions had threatened or attempted homicide, and 29% of the total sample had acted violently towards others (Planansky, 1977). He associated this with an excess of paranoid illnesses in

the 'homicidal' group, and noted the commonest victims to be wives. This behaviour was more often found in cases where recurrent episodes of illness had occurred with good or poor remission than in the first admissions or the permanently institutionalised.

Violent behaviour and arrest are not exclusive to the schizophrenic group within psychiatric patients, nor exclusive to one or other sex. Rappeport and Lassen (1965,1966) examined arrest rates for males and females before and after hospitalisation. Arrest for serious crimes was higher in the 'psychiatric' than the general population, and schizophrenics accounted for 30% of arrests in the five years before and after 1947 the year of hospitalisation. Giovannoni and Gurel (1967) performed a similar study and found higher arrest rates for assault, homicide and robbery among expatients, looking at psychotic cases in particular. Zitrin (1976) exhaustively examined 867 patients and compared their arrest rate, over a four year period that spanned an index admission, with the arrest rate within the general population. The rates for crime other than murder or robbery were substantially higher in the psychiatric population, and schizophrenic patients were overrepresented in offences, accounting for half of all those charged. The 42 schizophrenic cases arrested for violent offences included 30 who had abused alcohol, drugs, or both. The prediction of such outcomes is difficult. Even the prediction of immediate violence is reported as related to detention under civil commitment by Rofman (1980), and as unrelated to civil commitment for possible danger to others by Yesavage (1982).

Grunberg (1978) analysed the occurrence of mental illness in 48 cases of homicide, selected before and after the advent of a

community based hospital policy. The numbers are small, 48 cases, and the cases classified upon the basis of a verdict and the presence of past psychiatric hospitalisation only. He concludes however that during the period when deinstitutionalisation of psychiatric care was occurring locally there was an increase in homicide by the mentally ill. The part that schizophrenia plays in this is unclear, although a move away from longterm care applies to this group above other psychiatric diagnoses.

Schizophrenia is thus for some individuals a lifetime of disability, and yet the diagnosis may be applied by clinical and research methods to cases in whom a lasting remission is achieved. Hence at first presentation where the outcome is unknown the question of longterm prophylaxis over years is raised. Spontaneous involuntary movement disorders are reported to occur as a late complication of prolonged exposure to neuroleptic drugs, (Crane, 1973). Estimates of such movement disorder vary from 0.5 to 40% and such disorders do not invariably remit after cessation of drug treatment. (Gardos et al., 1978) Schonecker (1957) introduced the phrase tardive dyskinesia to describe such movements related to drug treatment, which may occur after treatment of only one year or less (Johnson D., 1977). Short term side effects of drowsiness, increased muscular tone, tremor and weight gain may be poorly tolerated by a particularly youthful population (Kennedy, 1980). The potential for relapse, readmission and the social disruption to the pattern of the individuals life must be weighted against these unwanted effects, with the additional proviso that drug treatment has been reported to increase (Astrup and Noreik, 1962) and to impair social functioning in these cases (Rappaport, 1978).

CHAPTER II

MATERIALS AND METHODS

A The Collaborators

B Referral and Assessments

Present State Examination

Psychological Impairments Rating Schedule

Disability Assessment Schedule

Past History and Sociodemographic Description Schedule

Disturbed Behaviour Rating

Expressed Emotion Ratings

C Follow up Assessments

D The Assessors

Chapter IIA The Collaborators

The investigation was designed to collect a large sample of patients suffering from their first treated psychotic illness which was not unequivocally affective in nature; and to assess the presentation and short-term outcome of such a population.

It was from this initial sample that two subsamples were drawn. One group of patients participated in a trial of maintenance neuroleptic medication versus placebo medication in an effort to determine the benefit of such treatment following first schizophrenic illnesses. Another overlapping group of patients were investigated in terms of the home emotional atmosphere which has been implicated in the prediction of relapse of schizophrenic illnesses. These two subsamples and their selection and assessment will be more fully described in Chapters 5, 6 and 9.

It was estimated that a consultant psychiatrist working within the National Health Service might see, in any one year, between eight and ten patients suffering from a first schizophrenic illness. The assistance and collaboration of consultant psychiatrists working at ten different hospitals within a thirty mile radius of Harrow, N.W. London, was obtained.

The Base Hospitals

1) Friern Barnet Hospital, London N3

Dr Bowman	Total inpatient beds	977
Dr Hailstone	Acute inpatient beds	156
Dr S. Mann	Total admission 1979	1,387
Dr Pitcher	Total discharges '79	1,429
Dr Sergeant	Catchment area population served	481,120

A large mental hospital situated within a surburban area of north west London, Friern Barnet Hospital has links with the Royal Free Hospital, Hampstead. There are extensive grounds in the hospital, and day hospital and rehabilitative services. Villas comprising of approximately four wards are designated to serve particular sectors of the catchment area. Much of the outpatient consultative work is located at the Royal Free Hospital Hampstead, which also has its own sixty bedded acute admission ward.

Royal Free Hospital Catchment area North Camden 105,000

2) Hill End Hospital, St Albans

Dr Alapin (retired)		
Dr Hajioff	Total inpatient beds	528
Dr Nanayakarra	Acute inpatient beds	104
Dr Salasa	Total admission 1979	742
Dr Sebastian Pillae	Total discharges 1979	764
	Catchment area population served	331,300

Situated at the edge of the cathedral town of St Albans, Hill End Hospital has a strikingly rural setting. The catchment population served is geographically scattered, and community based nursing services are well developed. Outpatient attendance for the referred cases is located at West Hertfordshire Hospital, within the centre of the new town of Hemel Hempstead.

3) Faringdon Wing, Luton and Dunstable Hospital, Bedfordshire

Dr B. Chester	Total inpatient beds	75	Day Hospital places	100
Dr Pinto	Total acute beds	25	(50 for inpatients)	
	Total admissions 1979	511	(191 new patients)	
	Total discharges 1979	510		
	Catchment population served	168,000		

Faringdon Wing is a purpose built psychiatric block attached to an active district general hospital. The catchment area includes immigrants from the Asian continent and of West Indian origin. The towns of Luton and Dunstable are highly reliant upon the motor manufacturing industry. The relative inexpense of housing compared with that of London has attracted a youthful population. There is a well developed community based nursing service, and outpatient clinics within the District General Hospital.

4) Napsbury Hospital, Hertfordshire

Dr Cordingly	Total inpatient beds	990
Dr Pariente	Total acute beds	26
Dr Ratna	Total admissions 1979	292
	Total discharges 1979	267
	Catchment population served	146,000

Napsbury Hospital is located in rural Hertfordshire, with small towns nearby. The catchment area extends well into the edges of the densely populated areas of north west London. Of recent years a growing emphasis on community based services has developed, and the majority of referred patients are assessed in their home environment. Frequent home visits by medical and paramedical staff are deployed, thus facilitating management at home as an alternative to hospitalisation.

The outpatient follow up is organised both as home visiting and attendance at a district general hospital (Edgware General Hospital) in north west London.

5) Psychiatric Unit, Northwick Park Hospital/Clinical Research Centre, Harrow, Middlesex

Dr Carney	Day Hospital places	80
Dr Crow (Clinical Research Centre)	Total inpatient beds	70
Dr Cunningham Owens (NHS/CRC)	Total acute beds	60
Dr Jeffreys	Total admissions 1979	-
Dr E. Johnstone (Clinical	Total discharges 1979	513
Research Centre)	Catchment area population (NHS beds)	144,100

The buildings consist of the Northwick Park District General Hospital and the Clinical Research Centre. As with other clinical departments, the Psychiatric Unit has a research ward incorporated in its fabric. There are the usual facilities of day hospital, and acute admission facilities. Patients from the catchment area and beyond may be investigated and treated in the 10 bedded research ward. The catchment area is one of relative affluence and social privilege. Community nursing services and outpatient facilities are available.

6) Saint Bernards Hospital, Greenford, Middlesex

Dr Baruche

Dr Baraniecka

Dr Silverman

A large mental hospital, St Bernards Hospital is situated in Southhall on the border of greater London. The catchment area extends to the south and west incorporating less densely populated areas.

The population served ranges from the relatively higher social classes based in Ealing where the British Broadcasting Corporation is a major feature, to the predominantly Asian population of Southhall.

7) Saint Johns Hospital, Aylesbury

Dr Candy

St Johns Hospital has extensive grounds that once incorporated a farm and an orchard. The hospital has a special Mother and Baby Unit and a relatively high incidence of Huntington's Chorea occurs in the population served. The new town of Bletchley with an excess of social difficulties is the responsibility of St Johns, and there are outpatient and psychiatric nursing services based within the new town.

8) Woodfield Wing, St Mary's Hospital, Harrow Road, Paddington, London

Professor Priest	Total acute beds	56
Dr Granville Grossman	Total admission 1979	386
Dr Tonks	Total discharges 1979	366
Dr Montgomery	Catchment area population	45,000

Woodfield Wing is a purpose built psychiatric block attached to the District General Hospital serving the mobile population of Paddington. The academic department with its involvement in research and teaching combines with the catchment area service to provide comprehensive facilities, including community psychiatric nursing and a busy day hospital. Outpatients attend at the Woodfield Wing. The nature of the population does cause difficulties with follow up.

9) Shenley Hospital, Radlett, Hertfordshire

Dr C. Benedek	Total inpatient beds 1334
Dr Dunstan	Total acute beds 98
Dr R. Henryk-Gutt	(Mother and Baby Unit 8 beds)
Dr Hershon	Total admissions 1979 829
Dr Huq	Total discharges 1979 764
Dr Knapman	Catchment population 296,035
Dr Shah	
Dr Stonehill	

Built in the 1950s, Shenley Hospital was designed on the villa system, with extensive grounds. Four acute admission wards served separate catchment areas. Some difficulty in communicating with an immigrant population of West Indian culture pertained to parts of the catchment area.

Wembley Hospital has a small inpatient facility, limited however by unavailability outside the working week, and an outpatient commitment.

10) Psychiatric Unit, Whittington Hospital, Highgate

Dr Bruce	Psychiatric beds 90
Dr Bardsley	Total discharges 1979 449
	Catchment population 180,000

The psychiatric block is new and purpose built, attached to

the Whittington District General Hospital. There are day care and community care clinics, and outpatient attendance services. Longer term care is available at Friern Barnet Hospital.

There was considerable overlap between the base hospitals from whence referrals came. The total catchment area population of those referred was at least 1,791,000 at its maximum, although this altered through the course of the study. Some consultant staff moved post or retired, and when patients moved to another locality the assistance and collaboration of other consultant staff was sought.

Other collaborators involved in follow up of patients:

Dr Edwards	Royal South Hampshire Hospital, Southampton
Dr Antony Finnegan	The Simmerton Health Centre, Oxford
Dr Meakin	Woolston, Southampton
Dr R.J. O'Riordan	St Augustine's Hospital, Canterbury, Kent
Dr Pamela Pilkington	Lond Grove Hospital, Epsom, Surrey
Dr J. Price	Community Hospital, Milton Keynes, Bucks
Dr J.E. Ryder	Margate, Kent
Dr Spencer	Warneford Hospital, Oxford
Dr J. Stead	The Royal Sussex County Hospital, Brighton.

Chapter IIB. Referrals Assessments

Referral

The referrals were made to the trial centre, at the Clinical Research Centre, Watford Road, Harrow by the clinicians at the base hospitals. The criteria for initial referral were the patient be aged between 15 and 70 years, and be admitted to day or inpatient care for a first psychotic episode that was not in the opinion of the referring clinician unequivocally affective in nature.

Referred cases were assessed at their base hospital with the consent of the responsible clinician and the patient.

Assessments

The schedules used in this study were largely drawn from the World Health Organisation study of schizophrenic patients in the International Pilot Study of Schizophrenia (Jablensky et al, 1980). Some additional assessments were made based on work with families of schizophrenics (Leff and Vaughn 1981) and ratings of behavioural disturbance during the initial phases of the illness were devised by the research team.

a) Assessments with the patient

The Present State Examination (Wing et al 1974)

This semistructured interview enquires of the patients' experiences over the preceding month, systematically covering all the mental phenomena which are considered when making a full examination of the mental state. A section for rating observed behaviour of the patient is incorporated in the schedule. The ratings of each item are coded according to laid down criteria, for most items as absent, present or severe. This schedule can be used to provide a computerised diagnostic category with the aid of the Catego Program; and this has been extensively tested in the past (International Pilot Study of Schizophrenia, WHO 1973).

The interview requires a degree of co-operation on behalf of the patient; severely disturbed patients can generally co-operate with at least some parts of the interview. In this study a sufficient command of English was necessary to complete the present state examination, although the PSE schedule is available in many languages.

The schedule begins with an open enquiry as to the main difficulties the patient has experienced over the preceding month, and is subsequently divided into sections dealing with general health and tension, autonomic anxiety, thinking and concentration, leading to questions concerning depressed mood and later to sections dealing with perceptual abnormality and other phenomena. Where the patient responds positively to an initial discussion of such phenomena more detailed enquiry follows. If the patient initially or during the interview refers to symptoms,

for example, hallucinatory experiences, the interviewer moves to the relevant section of the schedule for further enquiry. In many cases it was appropriate to immediately explore the presence of psychotic phenomena, thus neglecting the earlier parts of the schedule either entirely, or until later in the interview.

For some patients only limited parts of the schedule could be completed, such as in the presence of persistent gross formal thought disorder. Patients who initially could not co-operate with the interview were often able to do so later in their admission, after some improvement in their mental state.

The Psychological Impairments Rating Schedule (Jablensky et al, 1980).

This schedule is concerned with only the observed benaviour of the patient at interview. It is divided into sections, dealing with slowness, distractability, sleepiness, initiative, each section rating individual items as well as an overall impression. More complex behaviours such as social skills, body language, displayed affect and self presentation, co- operation and conversation skills are similarly broken down into individual items and rated as on overall impression. A final section dealing with a global impression of the patient's personality was completed, but may be of limited value in such a disturbed population of patients.

The Psychological Impairment Rating Schedule was completed at the Present State Examination interview, but where the patient was unable to participate in the Present State Examination initially a

PIRS was completed. Where possible the PIRS completed at full PSE interview was used for analysis.

b) Assessments with the Nursing Staff

Disability Assessment Schedule (Jablensky et al, 1980).

The whole schedule was completed in two parts, one with the patient's relatives, one with the nursing staff caring for the patient.

Disability Assessment Schedule (Nursing)

When the patient had been in day care or inpatient care for two weeks or more, this schedule was completed on the basis of information from a member of the nursing staff who had dealt closely with the patient. The behaviour of the patient in terms of slowness, activity, social withdrawal and conversation skills was rated, with information on violent behaviour or obviously bizarre behaviour (such as talking to voices) all being rated on a three point scale. Only the behaviour displayed in the preceding week was considered. The degree of supervision the patient required from constant supervision to none and the reasons for this supervision was also coded.

c) Assessments with the Relatives

Consent was sought from referred cases to contact and interview their relatives. Where possible relatives actually

living with the patient were seen, otherwise a near relative was contacted. For some patients living in lodgings both the landlord and a relative was seen, but this was uncommon. Some patients lived alone, and for some no relative was available, and in these cases partial, largely historical, information was then gleaned from the patients themselves. Generally the following schedules were completed at one interview with the informants.

Disability Assessment Schedule (Relatives)

Direct questioning of the informants about aspects of behaviour was used to supplement the spontaneous account. The ratings concerning the behavioural pattern over the month preceding admission were completed on a six point scale. The patient's self care, activity, interest and social withdrawal were assessed, and the performance of social roles as being a participating member of a household, as a spouse, as a parent, were estimated. Enquiries into interpersonal friction outside the immediate household, the performance in occupation and/or seeking occupation and the ability to cope with a crisis were also made. Any change, and the nature of such change, in these behavioural patterns from one year previously was rated on a four point scale.

The DAS contained a section dealing with modifying factors which might influence the patient's ability to cope with the illness, or the illness itself, such as privileged or deprived social circumstances, the presence of physical difficulties (eg deafness or diabetes) the maintenance of a special interest or hobby, or the presence of special skills. The presence or absence

of confiding relationships outside the immediate family and where relevant heterosexual interests were assessed, as was the patient's access to and use of privacy.

The Past History and Sociodemographic Description Schedule (Jablensky et al, 1980).

Adapted from the World Health Organisation Schedule (Jablensky et al, 1980) this schedule was used to collect historical information concerning personal data, the presentation of the illness and items of personal and family history. The schedule incorporated life events over the year preceding admission to hospital. It was completed on the basis of information from the nearest relative, on occasion the whole family, and on occasion from family and landlord. In some cases the patient alone was able to offer information. Data concerning medication, admission and discharge dates supplement the case note examination. Information spontaneously presented by the informant was placed on the schedule in long hand. The emphasis in the schedule upon historical information was not considered to supervene the necessity to allow the informants to discuss the illness, its nature and effect, and such discussion was of assistance in rating parts of the Disability Assessment Schedule concerned with the home atmosphere and key relatives attitudes. A brief outline of the schedule follows.

Past History and Sociodemographic Description Schedule

1) Personal data

age sex and date of birth

nationality and mother tongue

name and relationship of main informant

relationship of other informants

other information sources.

2) Personal history

education duration and attainments

work current employment status

best employment ever

most recent employment

psychosexual adjustment

lasting heterosexual relationships

homosexual relationships

use of alcohol/use of drugs/past criminal offences

3) Social situation

living situation

marital status

duration of marriage, children

spouse - education

evidence of mental illness.

4) Family history

parents education/employment

mental illness in family

5) Current illness of patient

presentation nature of onset/date of onset/date of admission

date of initial contact with medical services

number of contacts with services medical

social

religious and others

hospitalisation date of discharge

treatment neuroleptics/anxiolytics/antidepressants/ECT/other

6) Life events schedule - over 12/12 preceding admission

7) Spontaneously presented information

The interview was used for direct enquiry as to previous psychotic episodes.

The Disturbed Behaviour Rating

This rating was devised by Dr Eve C. Johnstone and the author. It became clear that much of the spontaneous information offered by relatives concerned the actual behaviour of the patient

during the days, weeks or months leading to admission. A simple scale rated four specific behaviours and a fifth (bizarre inappropriate behaviour) as absent, present at least once, present repeatedly over a period of one month, or present repeatedly for longer than one month.

The behaviours were designated as

1) potentially threatening to the life of the patient
2) potentially threatening to the life of others
3) disturbed or inappropriate sexual behaviour
4) behaviour damaging to property
5) bizarre inappropriate behaviour that is none of the above.

This schedule was retrospectively completed on the basis of the P.H.S.D. and DAS ratings, and rated during the PHSD interview from August 1980 onwards. Information from the initial case notes was used for this rating where appropriate. Information concerning this kind of behaviour which came to light after the patient was discharged from hospital was considered too unreliable for use.

Expressed Emotion Ratings

A subsample of the total referred population was investigated in an attempt to replicate the work of Brown & Rutter (1966) and Leff & Vaughn (1981), in examining the influence of family life on the course of schizophrenic illness.

Patients who had been living with others for three months or

longer prior to admission and who satisfied the criteria for a first psychotic episode were eligible. Patients from homes where English was not the spoken language or from unassimilated immigrant homes were excluded.

The senior social worker, Mrs A. Gold, was trained in the technique of rating expressed emotion by Dr J. Leff's team at the Institute of Psychiatry, Denmark Hill. Throughout the investigation Mrs Gold was in regular communication with Ms L. Kuipers, and interrater reliability was assessed.

Mrs Gold sent an explanatory letter requesting permission to visit and to tape record an interview with relatives of patients previously assessed by the research psychiatrist. An assessment of the hours of face to face contact during an average week in the past month was made by Mrs Gold, and she rated the tapes in terms of expressed emotion. The measure were of frequency counts of both critical and positive comments made over the duration of the interview, and an overall scaled rating of hostility, over-involvement and warmth expressed towards the patient by the relative. Mrs Gold was given the patient's age and sex and date of admission and address by the research psychiatrist.

Chapter IIC Follow up Assessments

Patients who entered the drug trial had detailed follow up throughout their participation, which will be fully described in Chapter 5. Patients were reinterviewed at relapse or completion, although a full present state examination was not invariably performed.

Attempts to obtain information on the whole referred sample were made, with particular emphasis on rehospitalisation and employment data at the close of the study, with a maximum follow up period of two years. The date of the last contact with psychiatric services was noted and the reason for cessation obtained where possible. Where appropriate contact was made with the nearest relative or the patient or psychiatric staff for a brief verbal account of progress. The duration of follow up was highly variable and reference to this duration will be made when dealing with the outcome (Chapters 6,7).

Chapter IID. The Assessors

The above assessments were performed by staff of the Clinical Research Centre, Watford Road, Harrow. The author had been trained in the use of the Present State Examination by Dr J. Leff at the Institute of Psychiatry, Denmark Hill. Patients under the clinical care of Dr E.C.Johnstone were in general fully assessed by herself, although the PHSD interviews were occasionally done by the author. Patients referred from the base hospitals were usually fully assessed by the author. For a three month period a research student performed some of the DAS (nursing) assessments and was instructed in this and supervised by the author.

The interviews with relatives and nurses were conducted by the author, her senior colleagues and on occasion by medical staff at the Clinical Research Unit.

The Expressed Emotion ratings and interviews were exclusively performed by Mrs A. Gold under supervision from Ms L. Kuipers.

The greatest barrier to effective completion of the assessments was with the unassimilated immigrant population, of whom many had limited English. Three patients (HR/PEP/SBW) were German speaking but had fair English, and two completed the Present State Examination with ease, one with difficulty. Hostility, suspiciousness and muteness were encountered fairly frequently in patients and were sometimes severe, but not necessarily insuperable. The cultural setting of even second generation West Indian immigrants was reflected in the difficulty in assessing marital and parental status for these patients, and as child care frequently was the accepted role of the

grandparents, some ratings were simply not possible. Most of the relatives were interviewed at home and while the informality produced much spontaneous information, some direct questioning was inhibited by the presence of children and other relatives.

CHAPTER III

Introduction

The collaborating clinicians at the ten medical centres referred patients for assessment from 1 August 1979 until 2 December 1981. 462 cases were referred during this twenty-eight month period.

253 cases satisfied the research criteria for inclusion in the study of cases of 1st episodes of schizophrenia.

This chapter deals with the exclusion of the 209 unsuitable cases in Section 1, and then with clinical and sociodemographic details of the 253 suitable cases in Section II.

Section 1

Referral, assessment and exclusion of cases.

Brief details of excluded cases.

Discussion of the relationship between organic illness and the presentation in cases and of the nature of the excluded patients.

Section 1

Referral, Assessment and Exclusion

The collaborating clinicians notified the trial centre when a potentially suitable patient was admitted.

The referral criteria are tabulated below.

Criteria for referral 1 August 1979 -2 December 1981

Cases were to be

1) thought to be suffering from a first psychotic illness, which was not unequivocally affective
2) aged 15-70 years
3) admitted to full or partial hospitalisation for one week or longer.

Psychotic defined as: delusions and/or hallucinations occurring in clear consciousness

Referred cases were assessed at their base hospital by the research psychiatrist. The assessments have been detailed in Chapter II, and are listed below.

Assessments of referred cases

With the patient: Present State Examination
The Psychological Impairments Rating Scale

With the nursing staff: Disability Assessment Schedule

With nearest relative: Past History and Sociodemographic Description Schedule
Disability Assessment Schedule
Camberwell Family Interview
(Assessed by Social Researcher only)

From all available information : Disturbed Behaviour Rating.

A total of 352 Present State Examinations were performed, 269 by the author, 67 by Dr Eve Johnstone, and 16 by other staff at the Clinical Research Centre.

Clearly not all assessments were completed on all patients. Assessment ceased early when a case failed to fulfil one or more of the research criteria for further study. These criteria which define a first episode of schizophrenia are tabulated below.

Research Criteria of 1st Episode of Schizophrenia

All criteria to be fulfilled

a) Age 15-70 years

b) Admission to full or partial hospitalisation

c) A clinical diagnosis of schizophrenia

d) A Present State Examination yielding a computerised diagnosis (using the catego program) within a schizophrenic class; S, P or O major class required

e) The episode to be the first treated episode

f) No organic illness of probable aetiological implications.

Excluded Cases

The 209 cases who failed to fulfil these criteria are tabulated by exclusions in Table 3.1.

Table 3.1 Total Referred and Excluded Cases

Total referred cases			462
Excluded cases			
a)	Wrong age	3	
b)	Not admitted	4	
	Treated elsewhere	6	
c)	Clinical diagnosis not certainly schizophrenic	8	
d)	i) No Present State Examination		
	Patient refused	6	
	Clinician refused	6	
	Deaf	3	
	Language difficulty	11	
	Precipitous discharge	23	
	Not seen	5	
	ii) PSE Classification outwith P,S,O Catego classes	54	
e)	Not a first illness	65	
f)	Organic illness with aetiological implications	15	
Total Excluded Cases			209
Total First Episodes of Schizophrenia			253

Brief details of the exclusions a - d(i) are described in note form

a) Patients Case Nos 622, 525,537 aged 14, 71 and 73 years

respectively.

b) Patients Case Nos 271, 304, 523, 533 declined admission.

Cases treated elsewhere

Case No 600 Transferred to adolescent unit

Case No 188 Transferred mental handicap services

Cases No 376,621 Transferred to near home

Cases No 272,535 Treated acutely elsewhere and transferred into a base hospital.

c) Clinical diagnosis not certainly schizophrenic

Cases No 252,267,524,611 Probable psychotic illness

Cases No 235,375,378,534 Neurotic disorders or personality disorders.

d)(i) Failure to complete Present State Examination

Patients refusing. Cases No 158,199,294,295,519,559

Clinician's request:

Case No 618, participating in another research project

Case No 620, relatives very anxious

Case No 237, patient extremely disturbed

Case Nos 298,316,318, multiple reasons

Deaf patients: Cases No 273,360, completely deaf

358 almost entirely deaf.

Language difficulty:

West Indian "colloquial English" Pts 261,514

Hungarian speaking 206

Mute for some weeks 547

Native tongue: Arabic (Pt 548) Indian language with limited English (pts 265,279,307,574,585,627*)

* Pt 627. Died whilst inpatient due to injuries sustained whilst psychotic (see appendix).

Precipitous Discharge : effected by

Spouse : pts nos 197*, 592

Self discharge : pts nos 134,198,301,302,562,563, 565,599,601

Absconded : pts nos 584,613 no further contact

pts nos 303,308,377 admission later

Repatriated : pt 541

Unspecified : pts nos 250,551,569,588,578.

Not seen (author's error) pts nos 225,347,355,357,567.

*Pt 197. Died by drowning within a few weeks (see appendix).

dii) PSE Classification outwith P.S.O Catego Classes

In 54 cases the Present State Examination yielded a computerised diagnosis which did not support the clinical diagnosis of schizophrenia. 20 cases fell within the D (psychotic depression) class, 25 within the M class (hypomania) and 3 were classed as N (neurotic), 3 with R+ (reactive depression), 2 within A? (anxiety neurosis) and 1 with B+ (residual neurosis). These cases are tabulated by case number and PSE Major and Minor class.

TABLE 3.2

Present State Examination outwith the S, P, O Major Class.

Pt No	Subclass	Major Class	Pt No	Subclass	Major Class
064	PD?	D?	305	XN	X
100	MN+	M+	306	RD+	R+
113	MN?	M?	322	MN+	M+
119	PD+	D+	334	PD+	D+
126	PD+	D+	337	RD+	R+
129	MN+	M+	341	HM+	M+
140	PD+	D+	361	PD+	D+
141	HM+	M+	380	PD+	D+
142	PD+	D+	503	MN+	M+
167	PD+	D+	506	PD+	D+
171	PD+	D+	508	PD+	D+
182	PN+	A+	509	NO	B+
184	PD+	D+	513	PD+	D+
187	MN+	M+	518	MN?	M?
192	MN+	M+	532	MN+	M+
201	MN+	M+	546	HM+	M+
212	MN+	M+	550	PD	D
215	PD+	D+	557	HM	M
233	PN+	A+	558	AP?	D?
234	SD+	N+	575	MN+	M+
238	MN?	M?	576	PD+	D+
239	MN?	M?	587	MN+	M+
245	MN+	M+	595	HM+	M+
258	PD+	D+	597	MN+	M+
263	MN+	M+	610	HM+	M+
266	ON+	B+	612	RD+	R+
269	MN+	M+	626	PD+	D+

e) Not a first illness

In 65 cases a previous episode of psychosis was revealed.

The criteria concerning past episodes and its definition were stringent. Contact with services which clearly led to the index admission was considered as part of the first illness. Where contact and treatment had lapsed, regardless of evidence of remission, for longer than one month, this was evidence for a past episode. Where such past contact involved the suggestion of a psychotic illness or diagnosis, or treatment with neuroleptics, for longer than one week then this was considered as grounds for exclusion. Past admissions where treatment occurred for less than three days, in the absence of any suggestion of psychosis were not considered as evidence of a past episode. This was to permit the management of brief adolescent crises in such a fashion not to exclude patients who subsequently developed a schizophrenic illness. This applied to two cases (pts 044,067), one having an isolated contact concerning a failed heterosexual relationship, and the second patient having taken an overdose in response to parental marital dysharmony.

These 65 excluded cases and such details as are available concerning their past illness are tabulated. (Table 3.3).

TABLE 3.3

Past Psychotic Episodes

Outpatient neuroleptic treatment and/or diagnosis of psychosis			Past Admissions					
			Single			Multiple		
172	181	213	189	226	249	117	256	260
327	526	553	300	310	319	343	365	501
			325	339	370	510	511	515
			373	504	507	517	527	542
			516	520	521	543	560	564
			528	531	536	568	570	571
			554	555	556	591	593	596
			566	573	577	602	603	617
			582	583	586	623	624	
			609	615	616			
			625	629	630			
	6			33			26	

Fuller details are presented in the appendix.

f) Organic illness with aetiological implications

15 cases were excluded on the basis of organic illness with possible or probable aetiological implications. The cases with the diagnoses are listed in Table 3.4.

TABLE 3.4

Organic Cases

No	Sex	Age	Diagnosis
060	F	53	Squamous carcinoma bronchus
153	F	28	Autoimmune disease: cerebral atrophy
			Pericardial effusion
160	F	59	Syphilis
176	F	40	Sarcoidosis
216	F	36	Sarcoidosis
231	M	33	Drug abuse
247	F	33	Cerebral cysticercosis
274	M	38	Alcohol abuse and withdrawal
287	F	54	Syphilis
292	F	29	Hypothyroidism
328	M	17	Drug abuse
349	F	52	Syphilis
505	M	46	Alcohol abuse and withdrawal
598	M	45	Alcohol abuse
608	F	33	Head injury and hemiparesis

Full details of the presentation, investigation and diagnoses of these cases are presented at the appendix end.

Discussion

The relationship between the organic illness and the presentation of the 15 cases with organic disease

It is probable that the patient suffering from the sequelae of a head injury was referred before full clinical details were available.

A diagnosis of syphilis was made in two cases, all cases having positive specific serology. One case had some neurological signs on admission and another case developed epilepsy during follow up. Neither case however showed positive biochemical results in cerebrospinal fluid; and there are no details of cerebrospinal fluid examination in the third case. All patients were middle aged females presenting with florid paranoid psychosis in the absence of disorientation. The diagnosis of syphilis would perhaps not have been made in the absence of routine haemotological screening.

Syphilis is recognised to have psychiatric presentations, but it remains possible that in these three cases the disease is merely coincidental with the psychiatric state.

In 5 cases a diagnosis implicating drug or alcohol abuse as of major aetiological importance was made, all patients being males. The drug abusers were aged between seventeen and thirty-three years, in contrast to the alcohol abusers who were thirty-eight to forty-six years old. The history raised the diagnosis early in all cases bar the seventeen year old youth. Disorientation was not a major feature in any of these cases; but the improvement during withdrawal

appeared clear in all cases except the thirty-three year old drug abuser.

The female patient who was finally diagnosed as having a squamous cell carinoma of bronchus presented with a typical and florid paranoid illness. Repeated chest infections, heavy smoking and the poor response to treatment led to a search for an organic basis, but diagnosis was delayed. There was no evidence of disorientation on admission or until the patient became gravely physically ill. It is possible that the two disorders of psychosis and carcinoma were merely coincidental.

Hypothyroidism is associated with psychiatric presentations more commonly mimicing depressive illness, but cases of paranoid psychosis have been reported. The mental state of the patient did not change when the patient was rendered euthyroid having been slightly thyrotoxic. It is a tentative possibility that the long period of hypothyroidism, predating the psychiatric presentation by many years, may have had a bearing upon the psychotic illness.

Two patients suffering from sarcoidosis present similar difficulties to those with a diagnosis of syphilis. Although cerebral sarcoidosis is reporting in the literature with neurological deficits, the author failed to find reports of sarcoidosis associated with abnormalities in the mental state. In both cases the medical history was long and the sarcoid not evidently active at the time of psychiatric presentation.

Two unusual clinical conditions presented with psychotic phenomena. The patient suffering cerebral cysticercosis, with a long history of brief psychotic episodes and epileptic phemomena had functioned at a high social and academic level consistently. The

course of the psychotic features bore no relationship to classical schizophrenia, and the presence of disorientation is strongly suggestive that the cysticercosis was causative. The other patient, also an intelligent young female, showed marked decline of performance and gross personal deterioration in the presence of mild disorientation. The final diagnosis of autoimmune disease with cerebral atrophy and pericardial effusion is unsatisfactory only in that the disease did not follow a known pattern of recognised autoimmune diseases such as systemic lupus erythematosus.

The Nature of the Excluded Patients

At the close of the study the author had the opportunity to peruse some of the case records of the excluded cases. This unsystematic data is presented in the appendix. However, such perusal made it clear that the research criteria excluded some cases where a clinical diagnosis of first schizophrenic illness could be retrospectively applied very appropriately. The youth aged 14 years, excluded because of his age, experienced a prolonged psychotic illness with many first rank features of schizophrenia. One patient who did not come to admission did so one year later with a clearly schizophrenic illness and thence followed a fluctuating but deteriorating course. Two cases excluded as the clinical diagnosis of schizophrenia was not certain had illnesses resulting in mild but detectable impairment. The Present State Examination provided a computerised diagnosis in the affective classes for some patients who were prepared to reveal nuclear schizophrenic features at interview with others, but not at the formal completion of the PSE. Some of these patients followed the course of unremitting

psychosis with impairment.

No method of case definition and selection can overcome the fundamental difficulty in constructing a universally acceptable definition of an episode of schizophrenia. The assumption that the lack of a past history of psychosis defines the current illness as the first illness is undermined by some patients revealing a past illness very late during the assessment. Patient 504 recalled a first episode, many years previously, on reading the protocol sheet for entry to the drug trial. He was embarrassed to inform the author that he was not eligible for entry into the study of first episodes of illness.

One murder and two deaths are known to have occurred in this group of 209 cases. Patient 266 who received a clinical diagnosis of schizophrenia with morbid jealousy received a catego classification of obsessional neurosis. He murdered his wife two and a half years later. Patient 627 and 197 both died.

The total referred population and the excluded cases are tabulated by Medical Centre (Table 3.5).

TABLE 3.5

Hospital	Hill End	Naps	NPH	L&D	Shen	StM	Friern	StB StJohn	Whitt	Totals
Total Referred	19	12	86	99	156	29	30	19	12	462
Age/Deaf			0	1	3	1	1			6
Pt refused int					4	1		1		6
Clinic ref int	1			2	1			2		6
Language			2	3	6					11
Not admitted Rx elsewhere		2	4	2	2					10
Precipitous Dis	1		2	5	12		1	2		23
Rediagnosed clin			4	1	2		1			8
Not seen					3		1		1	5
Early exclusions	2	2	12	14	33	2	3	5	1	74
Previous episodes of psychosis	1	5	11	15	19	6	3	3	2	65
PSE does not confirm clinic diagnosis	2	-	6	18	20	1	6	-	1	54
Organic	-	-	4	3	6	1	1	-	-	15
Late exclusions	3	5	21	36	46	8	10	3	3	135
Total exclusions	5	7	33	50	79	10	13	8	4	209
1st episode patients	14	5	53	49	77	19	17	11	8	253

The Nature of the Sample II

Details of the 253 Cases

Year of admission

Present State Examination diagnosis

Sociodemographic

Sex age race mother tongue

Marital status and living conditions

Occupation at admission

Social class

Premorbid function

Heterosexual relationships

Criminal offences/alcohol/drug use in past 5 years

Family history of mental illness

Selected clinical variables

Nature of onset, period between onset and admission

Social withdrawal

Summary

Not all patients had all assessments. A syndrome check list was substituted in 4 cases for the Present State Examination to give catego classifications of the mental state for all cases. Where there was no relative to complete a past history and sociodemographic descriptive schedule the patient was asked to provide information. Basic information concerning age, sex, duration of hospitalisation and so forth was collected independently of the formal assessments where necessary.

The available assessments are tabulated below:

Assessment	Available	None
Present State Examination	249	*
Psychological Impairments Rating Scale	204	49
Disability Assessment Schedule (nursing)	167	86
Past History and Sociodemographic Description Schedule	192	61
Disability Assessment Schedule (relatives)	149	104
Camberwell Family Interview	82	171
Disturbed Behaviour Rating	222	31
Basic Information	253	-

[*Syndrome check list (derived from the PSE) used to provide computerised classification in 4 cases]

From these assessments the details of the cases were collated.

Year of Admission

The 253 cases were collected from 1 August 1979 until referral closed on 2 December 1981. The year of admission is displayed, with admissions being roughly equal from year to year.

Year of admission	No.	%
1969 (6/12)	47	18.6
1980 (12/12)	112	44.3
1981 (11/12)	94	37.1
Total	253	100

The Present State Examination Computerised Diagnosis

The Present State Examination provided a computerised diagnosis. These are displayed by major and minor class for the sample. In 4 cases a syndrome check list was used to provide the diagnosis.

Six cases fell within the D+ (depressive psychosis) class. These patients entered the study at a time when the computerised diagnostic facility was unavailable. Having entered, they continued to participate.

TABLE 3.6

PSE Catego Classification by Major and Minor Class

Major Class		Nos of Cases		% of Total
S+	central schizophrenia		202	79.8
	NS+	163		
	NS	7		
	DS+	18		
	NSMN/DSMN	3		
	NSPD	11		
P+	paranoid psychoses		29	11.4
	DP+	25		
	DPPD	2		
	DPMN	2		
P?	uncertain paranoid psychoses		8	3.2
	DP?	3		
	DP?/AP?	4		
0+	other psychoses		4	1.6
	CS+	2		
	RS+	1		
	CSPD	1		
0?	uncertain other psychoses		4	1.6
	SS	1		
	UP+	1		
	UP?	2		
D+	depressive psychoses		6	2.4
	DP+	6		
		Total	253 Cases	100%

Sociodemographic Details of the 253 Cases

Some of this information is displayed by medical centre at the close of the chapter, but is tabulated for the total sample here.

Sex		Age at Admission	Age at Onset
Male	148	mean 27.04 (7.6)	mean 24.4
			129 cases
Female	105	mean 29.9 (19.3)	mean 28.4
			94 cases
Total	253	mean 28.8 (10.7)	
		median 24.4 range 15-65 years	

The age difference between males and females was statistically significant at ($t=2.1$ 1df $p<0.05$) and was preserved when age at onset was compared ($t=2.37$ 1df $p<0.002$).

Racial Origin and Mother Tongue

Racial Origin	Nos of Cases	% 253	Mother Tongue	Nos	% 253
White European	166	65.6	English	205	81.0
Negro	54	21.3	European	16	6.3
Asian	24	9.5	Indian	20	7.9
Mixed Other	9	3.6	African	7	2.8
			Other	5	2.0
Totals	253	100		253	100

The sample was predominantly of white European origin, but the representation of negro, Asian, mixed and other races is probably a reflection of the catchment area. All patients spoke enough English to participate in the Present State Examination, but this was not the native tongue of 48 patients. The European languages spoken were French, German, Greek, Hungarian and Polish (4,1,4, and 6 cases respectively). Indian languages included Urdu, Hindi and Gujarati. African languages were not classified, but the other languages were Chinese, Mandarin, French-patois and Arabic (1,1,1, and 2 cases respectively). Five of the native English speakers were bilingual in Greek (2 cases), French, German and Polish.

The sample was predominantly single, and living alone or with parents, as might be expected in a youthful population.

Marital Status : Domestic Circumstances at Admission

Marital Status	Nos	%	Living with	Nos	%
Single	185	73.1	Alone	104	41.1
Married	43	17.0	Parents	85	33.6
Cohabiting	9	3.6	Spouse/Cohabitee	48	18.9
Divorced	12	4.7	Siblings	7	2.8
Widowed	4	1.6	Other relatives	6	2.4
			Unknown	3	1.2
Totals	253	100	Totals	253	100

The cases were admitted during the period 1 August 1979 until 2 December 1981, when unemployment was rising. The employment status of the total population is tabulated, with separate categories for students and housewives.

Occupational Status at Admission

Status	No	%	
Full time student	21	8.3	
Full time housewife	30	11.9	
Employed	100	39.5	(67 males 33 females)
Unemployed	95	37.5	(62 males 33 females)
Retired	4	1.6	
Uncertain	3	1.2	
Totals	253	100	

Assessment of social class of the sample, by the Registrar General's definition of social class by occupation is tabulated by three different criteria. These criteria are by occupation of father, by the most recent occupation of the patient, and by the peak occupation of the patient. Students, housewives and retired where occupation was not defined, and unknown are separately tabulated.

Social Class by Occupation Total Nos

Social Class by Occupation	Recent Occupation	Peak Occupation	Occupation of father
I + II	19	21	49
III manual and non-manual	80	90	87
IV+ V	64	52	36
Students/housewives retired	21	20	2
Unknown/not applicable (never employed)	69	70	79
Totals	253	253	253

The range of educational attainment was wide including one patient with a second degree, and at least two of the patients with no educational qualifications were illiterate.

Educational Attainments of Patients

	No	%
None	69	27.3
CSE/O levels	48	19.0
HNC/A levels	37	14.6
HND/First degree	11	4.3
Second degree	1	0.4
Unknown	87	34.4
Total	253	100

Premorbid Function of the Patients

Two crude assessments of social premorbid function are tabulated, firstly the formation of heterosexual relationships, and secondly, past criminal record, and abuse of alcohol and drugs.

Formation of Heterosexual Relationships

	No	%
Relationship of more than 6/12 duration formed	120	47.4
No attempt made	69	27.3
Tried but failed	22	8.7
Not applicable	5	2.0
Not known	37	14.6
Total	253	100

Criminal offences, use of alcohol and drugs, over past 5 years

Classification		Positive	Negative	Unknown	Totals
Criminal offences (past 5 years)		30	161	62	253
Use of alcohol (family tension/legal problems)		12	179	62	253
Hashish		37	154	62	253
with hallucinogens	5				
with amphetamine	6				
with alcohol	5				
with sedatives (non barbiturate)	2				

This information was obtained largely from interview with the nearest relative, and it is possible that relatives were anxious to give a favourable impression of the patient.

Fuller details of criminal records are given in the chapter concerned with judicial contact.

Family History of Mental Illness

Twenty-three parents and twenty-three children or siblings of the cases were classified as suffering from definite or probable functional psychotic illnesses. The information is tabulated, dividing the cases into those with and without a family history of mental illness, and further defining the nature of the mental illness.

Classification	Nos of Cases	%
No information	61	24.1
Enquiry reveals no family history	69	27.3
Family history (all mental illness) present	123	48.6
Total	253	100

The nature of the mental illness noted in first degree relatives is displayed below.

	Nature of Illness (nos)			
Relative	Functional Psychosis	Organic M. illness	Dependence/ Personality Disorder	Other
Father	12	1	6	4
Mother	11	1	7	7
Child	1	1	1	3
Sibling	22	1	6	1

Selected Clinical Variables

The time of onset was obtained from accounts of patients and relatives, and the nature of onset as acute, subacute, or insidious ascertained where possible. The period of time between onset and admission was calculated. These features are tabulated.

Nature of onset	No	%
1-7 days	31	12.2
7-29 days	40	15.8
> 30days	93	36.8
Unknown	89	35.2
Total	253	100

Period between onset + admission	No	%
<2 mths	71	28.1
2-6 mths	62	24.5
>6-12 mths	24	9.5
> 12 mths	66	26.1
Not known	30	11.8
Total	253	100

Social withdrawal is a concomitant of early schizophrenia which has been said to have prognostic significance. A rating of social withdrawal was attempted in only 148 cases, but is tabulated below, along with ratings of change in the behaviour during the preceding year.

Social Withdrawal in Mth Preceding Admission	Nos	Change During Preceding Year	Nos
No data	105	No data	105
No dysfunction	25	No change	36
Minimal/mild	33	Better	4
Moderate	62	Worse	55
Severe, inaccessible	15	Worse, but poor	
Unassessable	13	for 1 year	34
		Unassessable	19
Total	253	Total	253

Summary

The 253 case sample displayed an excess of males and a predominance of youth. Racial origin was compatible with the nature of the catchment area and marital status compatible with the age of the sample. The educational attainments and social class of the patients covered a wide range. 79% of the sample received a computerised diagnosis of central (nuclear) schizophrenia. Six cases of psychotic depression entered the sample.

Premorbidly 47.4% cases had formed a lasting heterosexual relationship at some time. Only 11.4% of the sample had past criminal records and similarly small numbers of patients had abused alcohol and drugs in the past. Nearly half the sample had a family history of some form of mental illness, but this was not predominantly in first degree relatives. Assessed onset was more

often insidious than acute, and it was as common to have a prolonged period of illness preceding admission as to have a brief period.

TABLES 3.7, 3.8 and 3.9. Some of the sociodemographic variables, relating them to the medical centres where the initial episode of illness was treated.

TABLE 3.7

Sex/Race/Mother Tongue of 253 1st Episode Patients

VARIABLE	MEDICAL CENTRES 1	2	3	4	5	6	7	8	9	TOT	%
Sex male	10	4	27	32	44	10	12	4	5	148	58.5
female	4	1	26	17	33	9	5	7	3	105	41.5
Race											
Caucasian	14	5	39	36	34	10	15	8	5	166	65.6
Negro (WI/A)			5	7	31	7	2	1	2	54	21.3
Asian			6	4	11	1		2		24	9.5
Mixed/other			3	2	1	1			1	9	3.6
Mother Tongue											
English	14	5	45	42	57	14	13	9	6	205	81.0
European			3	1	7	1	3	-	1	16	6.3
Indian			5	4	9			2		20	8.0
African					4	2			1	7	2.8
Other				2		2	1			5	1.9

Medical Centres

1. Hill End Hospital
2. Napsbury
3. Northwick Park/CRC
4. Luton & Dunstable Hosp
5. Shenley Hospital
6. St Mary's Hospital
7. Friern Barnet, Royal Free
8. St Bernard's & St John's
9. The Whittington Hospital

TABLE 3.8

Marital Status/Living Situation in 253 1st Episode Patients

	MEDICAL CENTRES										
VARIABLE	1	2	3	4	5	6	7	8	9	TOT	%
Marital Status											
Single	11	3	37	31	56	15	17	7	8	185	73.0
Married	3		10	11	14	3		2		43	17.0
Cohabiting			1	2	4	1		1		9	3.6
Divorced		2	4	3	2			1		12	4.7
Widowed			1	2	1					4	1.6
Living with:											
Alone	4	2	15	34	22	10	11	2	4	104	41.1
Parents	7	3	23	3	27	5	6	7	4	85	33.6
Spouse/cohab	3		13	10	16	4		2		49	19.4
Other relatives			2	2	9					13	5.1
Not known					3					3	1.2

TABLE 3.9

Nature of Onset, and Period between Onset and Admission by Medical Centre for 253 Cases

VARIABLE	MEDICAL CENTRES 1	2	3	4	5	6	7	8	9	TOT	%253
Nature of onset										253	100%
Unknown	1	2	13	12	36	11	8	2	4	89	35.2
Acute 1-7 days	1	0	9	5	8	6	-	2	-	31	12.2
Subacute 7-28 days	6	1	9	10	11	6	-	2	-	40	15.8
Insidious >30 days	6	2	22	22	22	1	9	5	4	93	36.8
Onset and Admission										253	100%
Not known	-	-	1	4	13	5	2	1	4	30	11.6
<2/12	3	1	14	16	24	8	2	3		71	28.0
2-6 mths	5	2	16	12	14	2	6	5		62	24.5
6-12 mths	1	-	5	3	10	1	3	1		24	9.4
> 12 months	5	2	17	16	3	4	1	4		66	26.5

Discussion

This sample is similar to groups of first episode schizophrenics reported in the literature. The nature of the study, where collaborating clinicians joined and left the study during the collection of the sample, makes any estimate of the population area this sample is drawn from of dubious value. Referral patterns varied, and as admission was a criteria for referral, the paucity of referrals from hospital with a strong emphasis on community care is to be expected. The age of the patient sample is in keeping with other studies, and the slightly later presentation and onset of illness in females. The fact that nearly 80% of the sample were classified as suffering from central schizophrenia by the Present State Examination may alsobe a reflection of clinical referral patterns.

28.1% of the sample were hospitalised within two months of onset, but 26.1% had a period between onset and admission of longer than one year. The range of this period was from days to eleven years or more, although where onset was more than one year previously the author found it difficult to obtain a very clear account of the timing of onset.

The range of educational attainments was very wide, and more than half the sample were gainfully employed, or students, or housewives. There is a suggestion that occupation has declined from peak to recent occupation. It is not possible to distinguish this shift from altered economic circumstances of the general population. However it is possible to relate these variables to outcome to some extent.

The range of backgrounds these patients came from suggests that

schizophrenia has been diagnosed in this sample using a fairly wide concept of the illness, without the requirement of poor premorbid function.

CHAPTER IV

Admission Procedures

Introduction

The contacts made during the period between onset and admission with caring and other agencies are discussed.

The mode of admission is described and related to these past contacts.

At completion of the Past History and Sociodemographic Description Schedule detailed accounts of contacts made by the patient or relatives with the caring services were obtained. These details, concerning contacts made between the onset of the illness and the date of admission are described. This information is available for 190 cases from the total sample of 253 cases. Limited information which concerns only the mode of admission was obtained retrospectively from casenote examination of the remaining 63 cases. The information for these two groups is considered separately, in Section I and II, and where possible the actual mode of admission is related to the accounts of contacts derived from the PHSD interview.

Details of the Mental Health Act 1959 (England and Wales) are given at the close of the Chapter (A Review of the Mental Health Act 1959).

Section I

a) Information concerning contacts with medical and other sources in 190 cases is described, giving details of the numbers of contacts with specific services and separating the sample into those contacting only a small number of services and those contacting many services.

b) The mode of admission is described for groups of cases having made few and having made many contacts in the period between the onset of the illness and the admission date.

a) Information as to services and contacts with services

At interview specific enquiry was made as to the number of contacts made with the following five services:

i. Family Practitioners
ii. Hospital
iii. Private Medical Services
iv. Social Worker
v. Religious bodies
vi. Marriage Guidance

during the time between onset of the illness and the date of admission. The numbers of contacts were noted from 0 to 9, with 9 accounting for nine or more contacts.

Any contacts with other services were coded as the same 0 to >9 scale under "other" services, and included contacts instigated by the judiciary or contacts with legal and voluntary agencies. They are listed below:

"Other" services: Citizens Advice Bureau

British Railways Police

Charitable Agencies

Community Psychiatric Nurse

Department of Health and Social Security

Embassies

Employers

Member of Parliament

Members of the Public

National Association for Mental Health

The Press

Self Help Groups, e.g. Alcoholics Anonymous / Agoraphobic Aid

Womens' problem page of Magazines

and Police contact (including contact with lawyers).

The number of contacts recorded excluded that final contact which resulted in admission. The contacts made with the services are displayed in Table 4.1, displaying also the total known to have made no contact, and the totals known to have been in contact.

TABLE 4.1

Contacts made in period between onset and admission in 190 cases (excluding the contact resulting directly in admission)

Services	Total Cases without Contact	Total Cases in any Contact	Nos of contacts made (nos of cases) 1	2	3	4	5	6	7	8	>9	Unknown
Family Practitioner	33	157	54	26	25	12	4	1	1	0	34	0
Hospital	54	136	86	26	13	3	1	0	1	0	6	0
Private Medicine	176	12	7	0	1	0	0	0	0	0	4	2
Soc.Worker	157	32	15	7	1	0	0	0	0	0	9	1
Rel. Bodies	173	16	11	1	2	0	1	0	0	0	1	1
Mar.Guidance	185	4	1	1	0	0	0	0	0	0	2	1
"Other"	122	67	41	9	1	0	0	0	0	0	12	1

In 4 cases it is not clear whether or not contacts were made with certain services (listed as unknown).

In 157 cases contact was made with family practitioner services in contrast to only 12 cases certainly making approaches to private medical services and only 16 cases approaching religious bodies. A minimal estimate of contacts made, given that contacts in excess of nine were accounted for as nine, is of 1185 contacts made by 190 cases, with 565 contacts with general practitioners, 237 directly with hospitals, 170 with judicial and other services and 110 with social workers. The fewer cases making contacts with less obviously medical agents include 46 or more contacts with private medicine, 33

or more with religious bodies and 21 or more with marriage guidance by only 12, 16 and 4 cases respectively.

It is clear that some cases approached more than one service. Table 4.2 denotes the number of cases making contact with one service only, and those contacting multiple agencies. Admission at first contact occurred in four cases. In 3 cases partial data does not yield the number of services contacted.

TABLE 4.2

Contacts with 0 - 7 agencies in 190 cases

Number of Services Contacted	Nos. of cases
Admission 1st only contact	4
1 service	40
2 services	82
3 services	41
4 services	14
5 services	5
6 services	0
7 services	1
partial data unknown	3
	190 Cases

b) The Mode of Admission related to the number of contacts made

Admission was considered to have been effected by the general practitioner either by referral to hospital or by request for a domiciliary psychiatric opinion or where the general practitioner instituted direct admission, with or without recourse to Sections of the Mental Health Act.

Direct hospital admission refers to the 14 cases where direct contact with a hospital department, such as a casualty department, resulted in admission without involvement of the general practitioner (Table 4.3).

Judicial admission included formal transfer of patients to psychiatric care under the auspices of the Mental Health Act, and

cases taken to hospital by the police, with or without the use of the Mental Health Act. 34 cases were admitted by these routes.

Those 11 cases where self-harm resulted in admission are discussed separately, and admission by other routes is discussed below for the 11 cases concerned.

Table 4.3 denotes the mode of admission, and the number of contact made by patient and/or relatives, or others preceding this admission contact. The number of preceding contacts are divided into contacts across several services, with a separate group of cases who had made at least 9 contacts with at least one service prior to admission.

TABLE 4.3

Admission related to number of preceding contacts: 190 cases

Mode of Admission effected by	Number of Contacts Preceding Admission Contact								
	0	1	2	3+4	5+6	7+8	9	>9 at one or more services	TOTALS
General practitioner	1	11	30	20	13	7	4	34	120
Hospital: direct contact only	1	6	2	3	1	0	0	1	14
Judicial services	1	8	5	7	4	2	1	6	34
Self-harm	0	3	3	1	1	0	1	1	11
None of the above	1	2	0	2	3	0	0	3	11
TOTALS	4	30	40	33	22	9	6	46	190

Details of Modes of admission, by nos of preceding contacts

Failed contacts

0 contact. 4 cases came to admission at their first and only contact with any service. One patient was admitted under Section 26 of the Mental Health Act instigated by the general practitioner, one patient was brought directly to hospital by his articulate and intelligent brother, the police brought a clearly disturbed youth informally to hospital. The fourth case was the daughter of two psychiatric nurses who made contact with medical colleagues, hence this is coded as 'other' mode of admission.

1 contact. Of the 30 cases coming to admission after one failed contact, 11 did so via the recognised route of general practitioner referral to hospital. 6 cases achieved admission by direct hospital contact, made with the help of employer (2 cases), a caring landlord (1 case) and by the patient unaided (1 case), or brought to hospital by a member of the public (1 case) and transferred from maternity services (1 case).

8 cases were admitted with judicial contact. These included 3 cases detained under Section 60 of the Mental Health Act, 1 case under Section 136, and 2 informal patients. The 2 other cases were detained under sections of the Mental Health Act when reaching hospital, one having been apprehended climbing the walls of a Royal residence, and one having been found trying to lift his car over a fence concluding a motorway chase.

3 cases came to admission following self-harm, in the form of 2 overdoses and 1 patient with fractured heels, having leapt from a car park on the basis of delusions.

2 cases were admitted via other means, one being employed in a

hospital and her supervisor making direct psychiatric contact on her behalf, and another brought to hospital from a railway line by British Railways Police.

2 contacts. Admission via the recognised route of general practitioner and hospital attendance achieved admission in 30 of the 40 cases.

Direct hospital contact made by a caring landlord (1 case) and by an itinerant Irish family on behalf of one of their many daughters (1 case) effected these 2 admissions.

Of the five cases with admission organised by the judiciary, 1 was charged, 1 was admitted under Section 136 of the Mental Health Act, 2 were brought to hospital informally seeking admission, and 1 was brought to hospital seeking emergency care for lacerations caused by a police dog.

The 3 cases of self-harm included 1 patient who finally came to psychiatric attention after a third large overdose, 1 patient who severely slashed her wrists in association with an overdose, and 1 patient who had attempted to poison himself with exhaust fumes some weeks previously. He had discharged himself before he reached psychiatric attention on that occasion, and his new employer, cognisant of the past event suspected the patient of further self-harm and organised direct admission.

3/4 contacts. 33 cases came to admission after 3 or 4 failed contacts. Again the bulk of the admissions (20) were instigated by the contact with the general practitioner services.

Direct contact with casualty departments, instigated by close relatives, resulted in 3 admissions. These all occurred in hospitals with psychiatric units.

3 cases were transferred to psychiatric care under Section 60 of the Mental Health Act, 1 case under Section 136 of the Mental Health Act, and 3 cases were brought to hospital informally by the police.

1 case was admitted after an ill organised attempt at self-harm, and the 2 cases with other modes of admission included 1 patient referred to the psychiatric services by the Samaritans and 1 patient admitted with the aid of a psychiatric community nurse who was in attendance upon the mother of the patient.

More than 5 contacts, but not more than 8 with any one service.

37 cases fell into the group, all having at least 5 failed contacts, and some having more than 9, but none having contact with any one service in excess of 9 times.

24 cases were admitted via the general practitioner.

1 case was taken directly to hospital, with considerable persuasion from relatives.

Of the 7 cases admitted by judicial intervention, 2 were brought informally and 4 taken to hospital using Section 136 of the Mental Health Act. The seventh case was transfered from prison under Section 60 of the Mental Health Act.

The 2 cases who came to admission following self-harm were gravely ill. 1 case had attempted to cut his throat and required a tracheostomy, the second case had made two past efforts at self-harm and another attempt required resuscitation in an intensive care unit.

3 cases brought to psychiatric admission by other routes were the result of a community psychiatric nurse in attendance upon the mother of one case, transfer from a hospital specialising in

neurological conditions in another, and the intervention of the British Railways police in the third.

At least 9 contacts with at least one service

46 cases had nine or more contacts with one or more services before admission was effected. The 11 cases which came to admission by routes other than the general practitioner are briefly described.

The one case admitted via direct hospital contact was brought to casualty by a staff member of a charitable hostel. The multiple past contacts had occurred with press, legal bodies and charitable foundations, all in efforts to convey delusional concerns with a conspiracy.

6 cases referred from judicial services included two cases where charges had occurred, (one of these being referred by an experienced probation officer), 2 cases were transfered from custody under Section 60 of the Mental Health Act, and 1 case taken to hospital informally. The sixth patient was admitted from the roof of his parental home, clad only in female underwear, with the involvement of the police, social worker and general practitioner.

The 3 cases admitted following self-harm included one patient who having taken an overdose, was contemplating amputating his penis, based on delusionary possession, and one patient taken to hospital by his schizophrenic sister following an attempt at self harm. The third patient was taken daily to his general practitioner by his father, but admission followed an ill organised attempt at self-harm. The father recognised his son as suffering an illness similar in character to that which had caused the mother of the youth to be chronically hospitalised.

3 cases were admitted by other routes, one being organised by

the brother of a patient, the brother being a general practitioner. One referral came via the school psychological services, and a social worker involved with the offspring of the third patient instigated admission.

Section II

Admission procedures for 63 cases with no information from the Past History and Sociodemographic Schedule

This information was not collected systematically and thus is separately presented. Information was obtained either from case notes or from an account by the patient. There is no systematic information as to attempts to seek aid prior to admission.

Admission affected by:

General practitioner	16
Direct hospital contact	3
Jucicial services	11
Self-harm	2
Other services	5
Unknown	26
	63 cases

The 16 cases admitted via instigation by the general pracititioner include one patient admitted under the auspices of the Mental Health Act when he began to carry a sharpened axe around with him, one patient admitted when she became unable to care for her adolescent daughter, one patient admitted after holding a knife to the throat of his wife, on the basis of delusions of jealousy, and one patient who had been gratuitously violent at home. Of the 3 cases admitted at direct hospital contact, all presented themselves for admission, alone. 11 cases came to psychiatric care via judicial services, of whom only 2 were brought to hospital informally. 3 cases were transferred under Section 60 and 5 detained under Section 136 of the Mental Health Act.

The 2 cases where self-harm occurred were dramatic. One patient presented himself at an accident and emergency department in the early hours of the morning. Before admission was effected he left and leapt from the roof of the hospital buildings, sustaining spinal injuries. The other patient stabbed himself, unexpectedly, and required an exploratory laparotomy. He was transferred from the surgical wards, but took his discharge (pt 163, 223 appendix).

In 5 cases admission occurred by unusual routes, including school psychological services; the intervention of a member of the public, taking the patient to hospital; a social worker referred the mother of two children who had had protracted absence from school due to the psychotic ideation of the patient (pt 148 appendix). One patient, who was a nurse, was admitted to psychiatric care by direct contact with medical colleagues, and the fifth patient was admitted via intervention from social services.

Discussion

The contacts made by relatives or patients were most commonly directed towards the general practitioner or hospital based services. The pattern of contacts with all services suggests that repeated contact occurred commonly, with the possible exception of judicial and hospital services. Admission occurring due to judicial contact or self-harm occurred in cases making few contacts and in cases where many contacts had been made.

The account of relatives emphasised the difficulty in achieving admission. The distress at being unable to achieve care for the patient after direct hospital contact had failed was eloquently described by relatives, who stressed that they were not given the opportunity to describe recent events to those dealing with the

patient. The burden of admission fell upon the general practitioner, but often this was delayed or admission by other intervention occurred.

Admission of a patient by implementation of the Mental Health Act may require that the practitioner feels the patient is a danger to himself or others by reason of mental illness. The assessment of dangerousness associated with mental illness is a difficulty much discussed in the psychiatric literature (Taylor and Gunn, 1984). In 13 cases self-harm precipitated admission, and violence towards others, sometimes of a trivial nature, and sometimes not, occurred in many cases (see Chapter 8). There is no clear allowance for disturbance which may cause the patient losses other than of life, unless a liberal interpretation of the Mental Health Act is taken. Many relatives, whilst distressed at police contact, were grateful that this led to admission. The difficulty in achieving admission was not exclusive to the socially underprivileged, nor was it related to making inappropriate contacts for aid. The working class relatives of patient 324, despite having made a huge range of contacts were unaware that they could play any part in compulsory admission implemented by the Mental Health Act. They had had contact with social services, but were informed of this right by a new family practitioner. The parents of patient 107, an honours graduate from a privileged home viewed his admission from the roof of his home with a mixture of relief and horror, the former predominating. Socially privileged families commented to the author not infrequently that they wondered how less fortunate families fared through the difficulties of admission.

The procedure for admission involving general practitioner and

hospital attendance may depend upon the willingness of the patient to participate. The issues of confidentiality, and discussion with relatives as to the activities of the patient and the need for admission, complicates admission procedures for this group of patients, who by nature of their condition cannot be expected to invariably understand their situation. The information presented in Chapter 9 includes accounts of the quantity and quality of distressed behaviour displayed by the patients, and the often protracted period between onset of the illness and admission. This confirms that standard admission procedures are not effective in this group of patients, and despite many patients having contact with family doctors and hospital services admission was rarely effected with ease.

There is little evidence of domiciliary psychiatric visits being used as an alternative to outpatient attendance. It is worthy of note that even when hospital contact was made this did not always result in immediate admission.

Summary of Rates of Admission

The rates of admission were:

1) General practitioner	136
2) Direct hospital contact	17
3) Judicial contact	45
4) Self-harm	13
5) Other than above	16
6) No information	26
Total	253 cases

The Mental Health Act 1959 (England and Wales)

Section 60 of the Mental Health Act

A court order, which may be applied when an individual is charged with any offence except murder, which transfers the individual to psychiatric care. A local hospital has to agree to take the patient, and the order lasts for one year.

Section 65 of the Mental Health Act

As above, but murder may be the charge, and the order lasts indefinitely, at the pleasure of the Secretary of State. Restrictions are placed upon the person's access to the community and parole must be granted by the Secretary of State.

Section 136 of the Mental Health Act

A police officer is empowered to take an individual from a public place to a "place of safety", if the individual appears to be suffering from a mental disorder and is in need of immediate care and control. In practice a place of safety is usually a hospital, or a police station, and the 72 hours the Section 136 lasts permits interview by medical and social worker and arrangements to be made.

Section 26 of the Mental Health Act

This Section has provision for compulsory admission and treatment, on the grounds that an individual is suffering from a mental disorder, and that it is necessary for the patient's health or safety, or for the protection of others, that the patient should be detained. The Section lasts one year.

The procedure requires an application to be made by the nearest relative or a social worker, and two medical recommendations are required. One of these practitioners must have recognised experience in the treatment or diagnosis of mental disorder.

Section 25 of the Mental Health Act

An order for compulsory admission which lasts 28 days, and has no provision for treatment. The requirements that the patient be suffering a mental disorder which necessitates admission on the grounds of health, safety, or the protection of others are the same as for Section 26. An application from the nearest relative or a social worker is needed, and two medical recommendations.

Section 29 of the Mental Health Act

This Section deals with urgent admissions, hence only one medical recommendation is required, and any relative (not just the nearest) may put forward an application. This Section detains the patient for 72 hours, the intention being to provide a second medical opinion within that time.

CHAPTER V

THE DRUG TRIAL

Introduction

120 patients participated in the double blind study of prophylactic neuroleptic medication following treatment for their first schizophrenic illness. The patients were followed up for a maximum of 2 years or until relapse, or until the close of the study or until contact was lost, whichever was earliest. Relapse occurred in 66 cases during follow-up, 46% of patients on active prophylactic drugs and 62% on placebo drugs experiencing relapse. Active medication was found to show a statistically significant reduction in relapse as opposed to placebo, when the duration of the total illness was accounted for. Using information concerning the readmission of the patients who did not participate in the drug trial, various factors of possible prognostic significance were examined. The total duration of the index illness from onset to discharge after treatment was found to have a highly significant effect upon relapse.

Materials and Methods

The management of the 253 cases during the index admission lay at the discretion of the responsible clinicians at the collaborating medical centres. At or around discharge the research team sought consent for participation in the drug trial.

The 120 patients who participated in the double blind trial of prophylactic medication were reviewed and managed as outpatients by their own clinical team at the medical centres, but had, in addition, access to the research team. The 133 non-participants partook of standard outpatient care and treatment.

Relapse was ascertained by the responsible clinician in the trial participants, and confirmed by the investigators after notification to the trial centre at the Clinical Research Centre, Harrow. Readmission data of the non-participants was collected at the end of the study.

a) Conduct of the Drug Trial

Contact was maintained with the 253 cases during the index illness. When discharge was approaching the researcher contacted the responsible clinician. Where the clinician was agreeable, consent for participation in the trial was sought from the patient and the nearest relative.

Participating patients were discharged on one and one only of a range of five maintenance therapies. The intention was to maintain the patient on that therapy throughout participation in the study. The choice of neuroleptic, from the five available, lay at the discretion of the clinician, with the proviso that the dose did not fall below the defined minimum. The use of other psychotropic medication, excluding other neuroleptics was freely permitted.

At discharge the staff pharmacist at the Clinical Research Centre randomly and blindly allocated cases to active or placebo group, within each chosen maintenance therapy. This was done using prepared sheets of allocation, and the intention was to ensure that equal proportions of patients receiving oral and intramuscular medication would receive active and placebo drugs.

A letter with the trial telephone centre number was given to the patient and relative, and an explanatory letter was sent to the family practitioner.

The Medication

All the neuroleptic medication used in the drug trial was prepared at the Clinical Research Centre, and delivered to an appropriate agency in three- monthly supplies.

The range of therapies, description of medication and the minimal dosage are tabulated.

Maintenance Therapy	Minimal Dose	Supplied as:
Chlorpromazine	200mg/day	50mg tablets
Flupenthixol	40mg/month	20mg/ml injection
decanoate		100mg/ml injection
Haloperidol	3mg/day	3,1.5mg tablets
Pimozide	4mg/day	4mg tablet
Trifluoperazine	5mg/day	5mg tablet

All patients received active drugs for the first month after discharge. The patients allocated to placebo treatment tailed to placebo treatment; over the second month they received matched but half-strength medication; and on the third month and thereafter received inactive treatment.

At Discharge		Nature of Treatment Given at Months		
		1	2	3+
Randomisation	1) active	active	active	active
	2) placebo	active	half strength	placebo

This strategy avoided the stress of discharge being simultaneous with the receipt of placebo medication, and in addition

served to preserve the double blind nature of the study.

Only the staff pharmacist at the Clinical Research Centre knew the true nature of the medication.

Patients were reviewed at least monthly for the first six months, by their own clinical team. Thereafter review occurred at least six weekly. Alteration of the dosage of therapy was noted, as was the mental state and social circumstances of the patient. The use of other medication was also noted.

Relapse was deemed to have occurred when the patient came to readmission for any reason, or where relapse was thought imminent and the certainty of active medication was considered a necessity. The clinician decided upon relapse, and notified the research team who then visited the patient to confirm and classify relapse.

The true nature of the medication for relapsed cases was made known to the clinician on request but the research team remained blind until the study closed.

b) The Non-Participants

These cases partook of entirely standard care and follow-up arrangements. At the close of the study readmission data was gleaned from case notes, from personal and telephone contact with patients, relatives, and medical and paramedical personnel.

This information is used to give a parallel of outcome in non drug trial participants, in the Prognostic Factors Chapter.

The Patients

Patients were required to have achieved discharge by 1st April 1982 to be eligible for participation in the drug trial. This date of discharge ensured the possibility of at least six months follow-

up. Seventeen cases did not achieve discharge by this date. A further 116 patients did not participate, and 120 entered the trial.

The social, clinical and demographic details of the 120 trial participants and 133 non participants are tabulated. The separation of these two groups, and the derivation from the total sample of 253 cases is shown below.

TABLE 5.1

Comparison of Trial Participants (120) and Non Participants 133)

Variable	Classification	Trial Participants 120	Non Participants 133
Sex	Male	74	74
	Female	46	59
Racial Origin	White European	83	83
	West Indian Negro	16	25
	African Negro	3	9
	Asian	14	11
	Chinese	1	0
	Mixed/other	3	5
Mother Tongue	English	95	113
	European	8	6
	Indian: Hindi/Gujarati	12	10
	Chinese	1	0
	Other	4	4
Place of discharge	Home	112	104
	Hostel	8	6
	Not known / NA	0	23
Employment	Employed	43	15
	Unemployed	72	81
	Day care	3	12
	Student/Hwife / NK/NA	2	25

TABLE 5.1 cont..

Comparison of Trial Participants (120) and Non Participants (133)

Variable	Classification	Trial Participants 120	Non Participants 133
Year of Admission	1979	28	19
	1980	59	53
	1981	33	61
Period between onset and discharge	<1yr	80	63
	>1yr	37	43
	Not known	3	27
Age at discharge	15-19	15	15
	20-24	38	40
	25-29	21	23
	30-34	10	14
	35-39	18	6
	40-44	10	10
	45+	8	8
	Not discharged	0	17
Present State Examination	S+	94	108
	P+	17	12
	P?	2	6
	O+	1	1
	O?	0	6
	D	6	0

Total 1st Episode of Schizophrenia	253 cases
Non Participants	
Not discharged by entry date	17
Precipitous discharge: not asked	13
Clinician unwilling	
discharge medication unsuitable	5
too well for prophylaxis	4
too unwell for placebo	35
Patient declined	42
Relative declined	17
Total Non Participants	133
Participants on prophylactic drug trial	120

The Results

These are described in the following sections:

a) drug allocation

b) other medication and treatment

c) baseline variables

d) relapse and categories of relapse

e) statistical analysis of the results.

a) Allocation to active and placebo medication was performed randomly within each chosen therapy. Very small numbers of patients were allocated to three of the four oral therapies, and this produced unequal numbers of patients on active and placebo treatment.

Maintenance Therapy	Total	Active	Placebo
Chlorpromazine	8	3	5
Flupenthixol decanoate	63	31	32
Haloperidol	9	3	6
Pimozide	13	5	8
Trifluoperazine	27	12	15
All cases	120	54	66

This uneven distribution to active and placebo arose purely by chance.

The range of dosages of the drugs used, and the use of other psychotropic medication did not substantially differ between active and placebo treated patients.

Maintenance Therapy Dose ranges for Active/Placebo per day [*per month]

	Active	Placebo
Chlorpromazine	366 (200-600)	250 (200-300)
Flupenthixol decanoate*	83.5 (40- 400)	85.9 (40-400)
Haloperidol	11.75(6- 19.5)	10.5 (3- 21)
Pimozide	7.75(4- 16)	5.5 (4-12)
Trifluoperazine	11.5 (5-20)	13.9 (5-45)

* Injected medication given once weekly to once monthly.

b) Other Medication and Treatment

The use of other psychotropic medication did not differ between active and placebo groups.

Maintenance Therapy	Total	Antiparkinsonian agents	Anti-Depressants	Minor Tranquilliser	Other Drugs
All Therapies					
Active	54	32	6	11	1
Placebo	66	32	2	12	5

Other Drugs:

	Active	Placebo
Lithium salts	-	1
Insulin	-	1
Anti-epileptic	1	1
Antihistamine	-	1
Thyroxine	-	1

The excess of placebo patients using other drugs arose entirely by chance.

c) The level of $p<0.2$ was chosen for comparison of the baseline variables. Imbalances of baseline variables are of importance when the variable has prognostic importance. While randomisation performed from prepared lists ensures that any imbalance occurs by chance alone, tests of significance are used to indicate how frequently a finding is likely to have occurred by chance alone. Altman states that it should not be concluded from a lack of statistical significance (at $p<0.05$) that imbalance in the distribution of a baseline variable did not affect the outcome of a trial (Altman 1984). The level of $p<0.2$ was thus taken to capture any imbalances in distribution of those baseline variables which might be associated with relapse.

The distribution of baseline variables between active and placebo treated groups demonstrates imbalances with respect to the period between onset and admission, the period between admission and discharge and the age of the patient when randomisation to active or placebo group was performed. The patients on active treatment tended to have a longer period between onset and admission (chi^2 = 8.41, 5df p=0.14) a longer period of hospitalisation (chi^2 = 5.41, 3 df p=0.14) and to be older at randomization (chi^2 = 10.1, 4df p=0.039) than the placebo group. For these comparisons of these variables $p<0.2$ was taken as statistically significant.

TABLE 5.2

Comparison of Active and Placebo Group by Baseline Variables

($p<0.2$ taken as statistically significant)

Variable		Active	Placebo	Total
Total		54	66	120
Sex	Male	35	39	74
	Female	19	27	46
Ethnic origin				
	White European	38	45	83
	West Indian	7	9	16
	African	2	1	3
	Asian	6	8	14
	Chinese/Oriental	0	1	1
	Mixed	1	2	3

TABLE 5.2 cont.

Variable		Active	Placebo	Total
Mother Tongue				
English		41	54	95
European		5	3	8
Indian		6	6	12
Oriental		0	1	1
Other		2	2	4
Place of Discharge				
Home		49	63	112
Hostel		5	3	8
Return to: at discharge				
Employment		23	20	43
Unemployment		29	43	72
Day Centre		2	1	3
Student		0	1	1
N/K		0	1	1
Year of trial entry	1979	4	8	12
	1980	31	33	64
	1981	18	25	43
	1982	1	0	1

Variable		Active	Placebo	Total	
Period between	<1	11	16	27	
onset and	1-2	6	9	15	
admission	2-6	9	22	31	Chi^2
(months)	6-12	7	6	13	= 8.42
	12-24	11	5	16	5df
	24-48	6	1	7	p = 0.14
	48+	3	5	8	
	NK	1	2	3	
Median (range)		5.7(101)	24(92)	2.8(101)	
Duration of	<2	0	3	3	
hospitalisation	2-3	4	4	8	Chi^2
(weeks)	3-4	1	3	4	= 5.41
	4-8	19	24	43	3df
	8-12	14	7	21	p = 0.14
	12+	16	25	41	
Median (range)		8.5(2-74)	8.0(15-40)	8.2(15-74)	
Age at	15-19	7	7	14	
randomisation	20-24	12	28	46	Chi^2
	25-29	9	11	20	= 10.1
	30-39	12	15	27	4df
	40-49	10	3	13	p = 0.039
	50-59	4	2	6	
Median (range)		28.2(17-59)	24.3(16-56)	26.3(16-59)	

Variable		Active	Placebo	Total
Present State Examination				
Major	S+	41	53	94
Catego	P+	10	7	17
Class	P?	0	2	2
	0+	0	1	1
	D+	3	3	6

d) Relapse and Categories of relapse

The outcome for all cases is described as:	No of Cases
No relapse at close of study or elapse of 2 years	41
No relapse but contact lost before close of study	13
Relapse due to deterioration in mental state	59
Relapse imminent, certainty of active medication now a necessity	2
Relapse and readmission on basis of reported behaviour	3
Relapse for other reasons	2
Total Cases	120

All of the 41 cases who remained relapse free were reviewed, but in one case this was done by letter and in one case by telephone. Two cases had continuing positive psychotic symptoms throughout follow-up but one of these maintained protected employment and the other was in long term day care. Mild or moderate evidence of lack of volition and drive was reported by the patient or relatives in twelve cases.

Contact was lost with the 13 other cases who remained relapse free at variable points during follow-up.

Appendix Case No	Date 1st trial medication prescription	Date contact lost	Reason contact was lost
030	18.01.80	29.01.80	Left area
052	18.03.80	19.03.80	Refused further contact
076	01.04.80	28.08.80	Left for Europe
106	10.07.90	29.10.80	GP declined further contact
110	26.06.80	04.08.80	Refused further contact
122	16.07.80	25.09.80	Left area: no trace
123	26.06.80	24.10.80	Left area: no trace
133	01.08.80	18.05.82	Refused further contact
151	06.11.80	28.01.82	Refused further contact
236	11.08.81	15.12.81	Pregnancy: withdrawn
242	12.05.81	10.12.81	Left area
283	03.06.81	18.06.82	Left for Middle East
309	30.07.81	21.08.81	Refused further contact

Relapse due to deterioration in the mental state resulted in simultaneous admission in 41 of the 59 cases. Recurrence of positive symptoms was confirmed by the research teams in 55 cases and a dramatic increase in positive symptoms in 3 cases, with the 59th case being admitted to prison where the forensic services confirmed recurrence of the psychosis.

Reported behaviour resulted in readmission in 3 cases. In 1 case this was clearly due to a recurrence of hallucinations and delusions, in the second case due to gross personal deterioration. The third case was admitted, floridly disturbed to a distant hospital, but the mental state was not reviewed by the researchers.

Two cases were withdrawn because relapse was thought imminent, and both patients were seen by the author. The first suffered increasing anxiety and hypochondriacal preoccupation, the second had an increase in his still present delusional beliefs.

The two other relapses included one death, reported as an open verdict by the coroner and one patient who was withdrawn because of noncooperation. He later confirmed his mental state to have deteriorated at that time.

The allocation of relapse within active and placebo treatment is shown below.

			Relapse Free	
	Entered	Relapsed	Complete	Incomplete Follow-up
Active	54	25	23	6
Placebo	66	41	18	7
All	120	66	41	13

e) The Statistical Analysis of the Results

For each patient the time period between the date of the first prescription of trial medication and relapse, close of follow-up, or loss of contact, or close of the study, as appropriate, was calculated to the nearest week. Actuarial percentage relapse free figures were calculated at weekly intervals for the active and placebo group, as well as for baseline variables, such as age and sex. The resulting relapse- free actuarial curves were compared using log rank testing (Peto et al., 1977).

The basic relapse free curve is displayed demonstrating a steady relapse rate over time. [see Graph 5.1]

Baseline variables were compared by constructing actuarial %

relapse free curves for subdivisions of these variables, and comparing them using log rank testing. Two baseline variables had an effect upon relapse, the first being employment after discharge and the second being a measure of the total duration of illness. (Table 5.3)

TABLE 5.3

Effects of Baseline Variables Upon Relapse

Comparison of actuarial % relapse free curves by log rank testing

Peto et al 1977 ($p<0.05$ Taken as Statistically Significant)

Variable	Comparison Between	Statistical Effect
Sex	Male	
	Female	$Chi^2=0.43$ 1df p=0.5 NS
Ethnic Origin	White European	
	West Indian Negro	
	Others	$Chi^2=3.14$ 2df p=0.2 NS
Mother Tongue	English	
	All others	$Chi^2=0.6$ 1df p=0.44 NS
Age Group	<20	
	20-29	
	>30	$Chi^2=0.88$ 2df p=0.65 NS
PSE Major Class	S+	
	All others	$Chi^2=1.03$ 1df p=0.31 NS
Drug Group	Chlorpromazine	
	Flupenthixol decanoate	
	Haloperidol	
	Pimozide	
	Trifluoperazine	$Chi^2=2.79$ 4df p=0.59 NS

TABLE 5.3 cont..

Variable	Comparison Between	Statistical Effect
Admission to date of 1st scr	<6 months >6 months	Chi^2=2.37 1df p=0.12 NS
Discharge Status [1]	Home Hostel	Chi^2=0.87 1df p=0.35 NS
Discharge Status [2]	Employed Unemployed	Chi^2=13.61 1df p <0.001 Significant effect
Period between onset and date of 1st script	>1yr <1yr	Chi^2=16.54 1df p <0.0001 Significant effect

Employment after discharge had an association with a lower relapse rate than discharge to unemployment. This is not necessarily an independent variable, and may be a generalised measure of a relatively brief illness not including loss of employment.

The effect of the duration of the total illness was statistically significant, indicating a higher relapse rate in those who had a total duration of illness in excess of a year (calculated from stated time of onset by patient and relative until entry into the trial at the date of the first prescription of trial medication). [see Graph 5.2]

The status of the patients, divided by period of total illness and into active and placebo maintenance therapy, as assessed at the conclusion of the study, is summarised in Table 5.4.

TABLE 5.4

Status of Patients at Conclusion of Drug Trial

Treatment Group	Entered trial	Relapse Free		Relapsed
		Complete	Incomplete	
Period between onset and 1st script <1yr				
Active	31	18	3	10
Placebo	51	18	7	26
Subtotal	82	36	10	36
Period between onset and 1st script >1yr				
Active	22	5	2	15
Placebo	13	0	0	13
Subtotal	35	5	2	28
Period Not Known				
Active	1	0	1	0
Placebo	2	0	0	2
Subtotal	3	0	1	2
All Cases				
Active	54	23	6	25
Placebo	66	18	7	41
Subtotal	120	41	13	66

The actual % relapse free is summarised for these groups with the standard deviation (where the number of patients at risk exceeds 10) in Table 5.5.

TABLE 5.5

Duration of Illness	Treatment	Actuarial % relapse-free months			
		6	12	18	24
Period between	Active	80(7)	80(7)	71(9)	59
onset + 1st script <1yr	Placebo	66(7)	45(8)	42(8)	42
	Subtotal	72(5)	59(6)	54(6)	48(6)
Period between	Active	76(9)	33	26	18
onset + 1st script >1yr	Placebo	23	8	0	0
	Subtotal	55(9)	23	14	10
All cases	Active	79(6)	62(7)	54(7)	42(8)
	Placebo	57(6)	37(6)	33(6)	30
	TOTAL	67(4)	48(5)	42(5)	35(5)

The crude effect of active versus placebo maintenance drugs failed to reach recognised levels of statistical significance, [graph 5.3], although there is a trend for placebo to relapse more.

When the sample was examined in terms of the duration of total illness it was clear that within the placebo treated group there was an excess of patients with a duration of total illness of less than one year.

Duration of illness	Active	Placebo
<1yr	31	51
>1yr	22	13
NK	1	2
TOTAL	54	66

Thus, by chance, the group who were maintained on placebo consisted of a large proportion who had a low risk of relapse by

virtue of the brief duration of total illness. The results were re-examined to take the question of duration of total illness into account.

This information is summarised below [see graph 5.4, 5.5].

Thus active maintenance treatment was superior to placebo in the prophylaxis against relapse of schizophrenia in this sample of first episode patients, Chi^2=9.40, 1df, p<0.005, when the effect of time is accounted for. The figures suggest that the benefit is greater in those with a longer period of total illness (Chi^2=6.50, 1df, p=0.01) than for those with a brief duration of illness (Chi^2=3.68, 1df, p=0.055).

Drug Effect

Maintenance treatment	Active Placebo	Chi^2=3.59 1df p=0.058 NS
accounting for period between onset and 1st script	Active)<1yr Placebo)	Chi^2=3.68 1df p=0.055
	Active)>1yr Placebo)	Chi^2=6.50 1df p=0.01
overall, accounting for period between onset and 1st script		Chi^2=9.40 1df p=0.002 Significant effect

Discussion

The prophylactic effect of active neuroleptic medication was found to be significant in the population of first episode schizophrenics (p<0.005), when the total duration of the illness from onset, through admissions, and to the point of discharge, was taken into account.

However this period, between onset and the time of the first prescription of trial medication, had a major effect upon relapse. Cases who achieved discharge within one year of onset had a lower relapse rate ($p < 0.0001$).

The incidence of relapse in this young population is high, with 65% of the population experiencing relapse by two years. Even with active treatment, and an outlook associated with a period between onset and discharge of less than one year, 41% had relapsed at two years. Amongst those maintained on placebo, and with a period between onset and discharge of more than one year, only 23% remained well at six months, and all had relapsed by eighteen months.

Hogarty and Goldberg (1974ii), Leff and Wing (1971), have demonstrated some 15% to 20% of schizophrenics to remain relapse free at two years, maintained on placebo. In this sample of first episode schizophrenics, 35% are relapse free at 24 months; and 20% of the original entrants remained relapse-free, maintained on placebo.

The impression from the literature that time has a very large relationship to outcome is strongly also replicated in this sample, and is of more impact than the use of long term medication. Gelperin in 1939 drew attention to this effect and felt it to be independant of treatment.

These results raise the question of the reasons for delay in admission and the possible effect of very early intervention in the illness. The lack of any significant effect of the duration of hospitalisation might be considered to support the contention that it is the lapse of time preceding treatment that is important. Such an interpretation cannot really be made where the duration of

hospitalisation may relate to hospital policy, the availability of community services and the attitude of patient, relatives and staff. The fact that these patients were to participate in a placebo controlled study at discharge may have had its own influence upon the point of discharge, and upon the use of facilities after discharge, as day care at the hospital was considered as part of hospitalisation in this study. The author would suggest that interpretation of the effect of the duration of hospitalisation is not possible in this study.

The association of return to employment with a lower relapse rate ($Chi^2 = 16.54$, 1df $p < 0.0001$) may be an effect of an all-embracing measure of prognosis. As shown in Chapter VII, loss of employment commonly occurred in the year preceding admission, often many months before admission. Keeping employment to return to is thus likely to be linked to a brief period of ill-health before hospitalisation, and may be associated with other socio-demographic variables such as education, which have been considered to have prognostic implications. To gain new employment after a psychotic illness is likely to require a major degree of recovery.

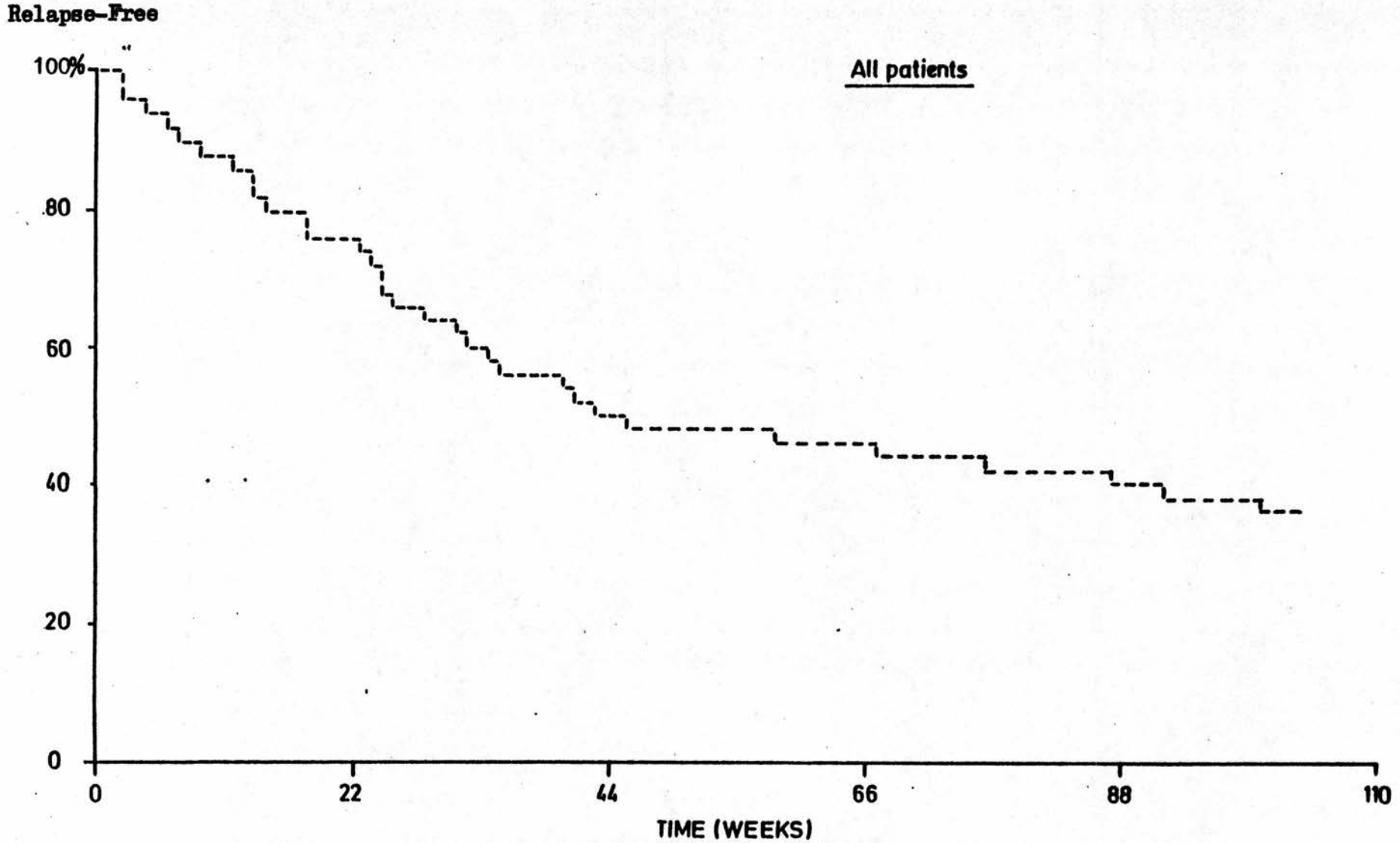
Two hypotheses may account for the increased risk of relapse associated with a period of more than twelve months between onset and discharge.

Firstly, some features of the illness may be a causal factor related to delayed hospitalisation, delayed remission, and early relapse. Such a factor could be negative symptoms of schizophrenia, such as withdrawal and social isolation. This isolation might lead to a delay in admission, so often resulting from disturbed behaviour in association with the positive symptoms of

hallucinations and delusions. However, if the negative features of schizophrenia are prolonged they may predict a generally poor outcome, but not necessarily relapse. Very poor cooperation could be a factor linking delay in admission to reluctance to continue with prophylaxis, and hence an increased chance of relapse. However, those who participated in the present drug trial were very cooperative. There was no apparent difference in relapse rates between those receiving intramuscular medication and oral medication, which would mitigate against a general lack of cooperation being responsible for the effect of time. It is possible that there is a group of patients in whom spontaneous remission is likely, and which is relatively lasting. Such patients would be over-represented in a group achieving admission and discharge with speed. If one considers the schizophrenic spectrum to include those in whom well being is briefly interrupted by illness, and to include those in whom illness is persistent and brief remission achieved only with difficulty, the dichotomisation of total illness time at one year may appropriately separate the two groups. What features determine these two hypothetical groups remains obscure.

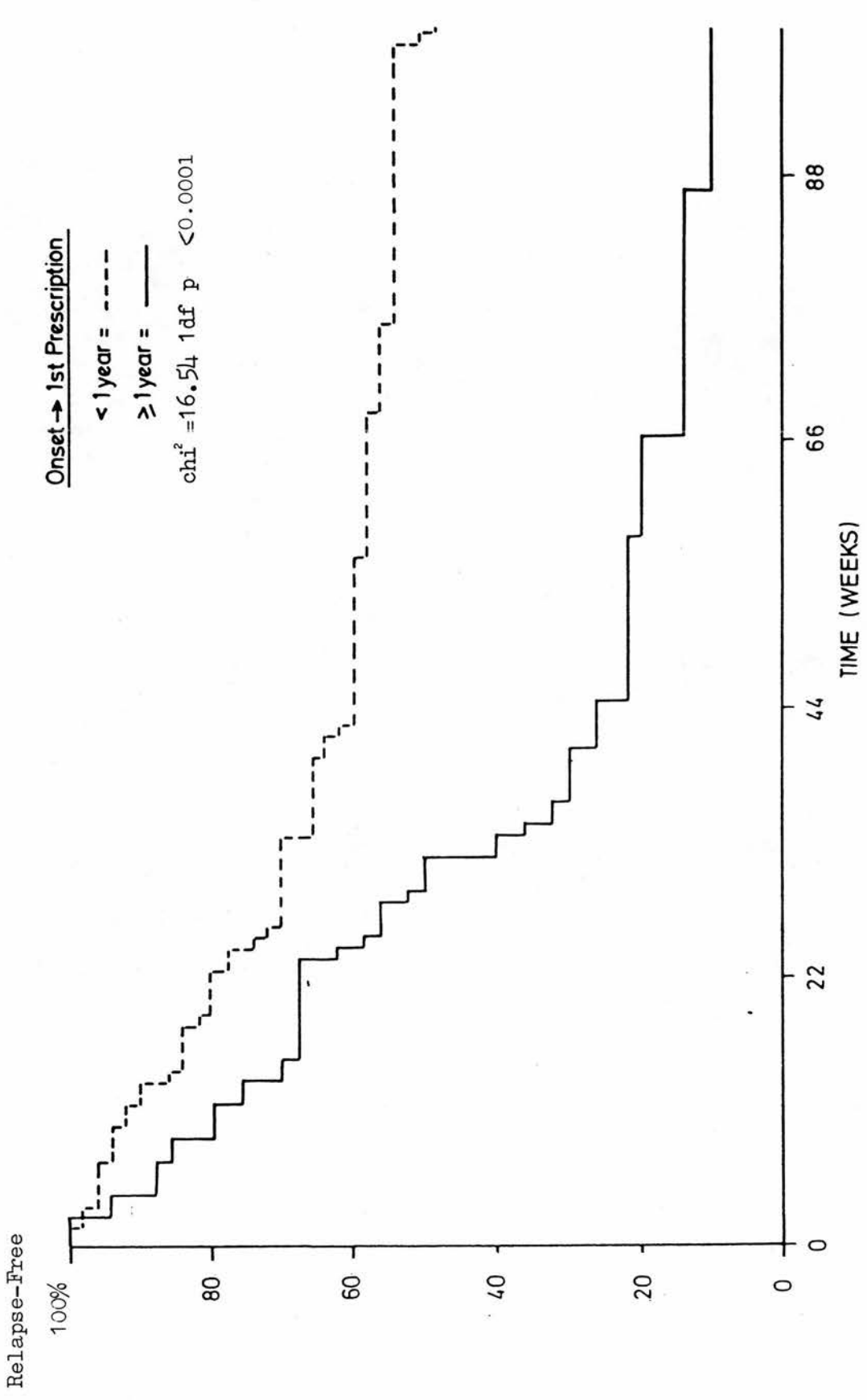
Secondly it may be that delay in treatment itself predisposes to a poorer outlook. This introduces the possibility that early intervention may reduce relapse rates.

These two hypotheses may not be mutually exclusive and the probability that most patients fall within the widespread range of good and poor outlook extremes suggest that early intervention practice might be explored in longterm follow-up studies.

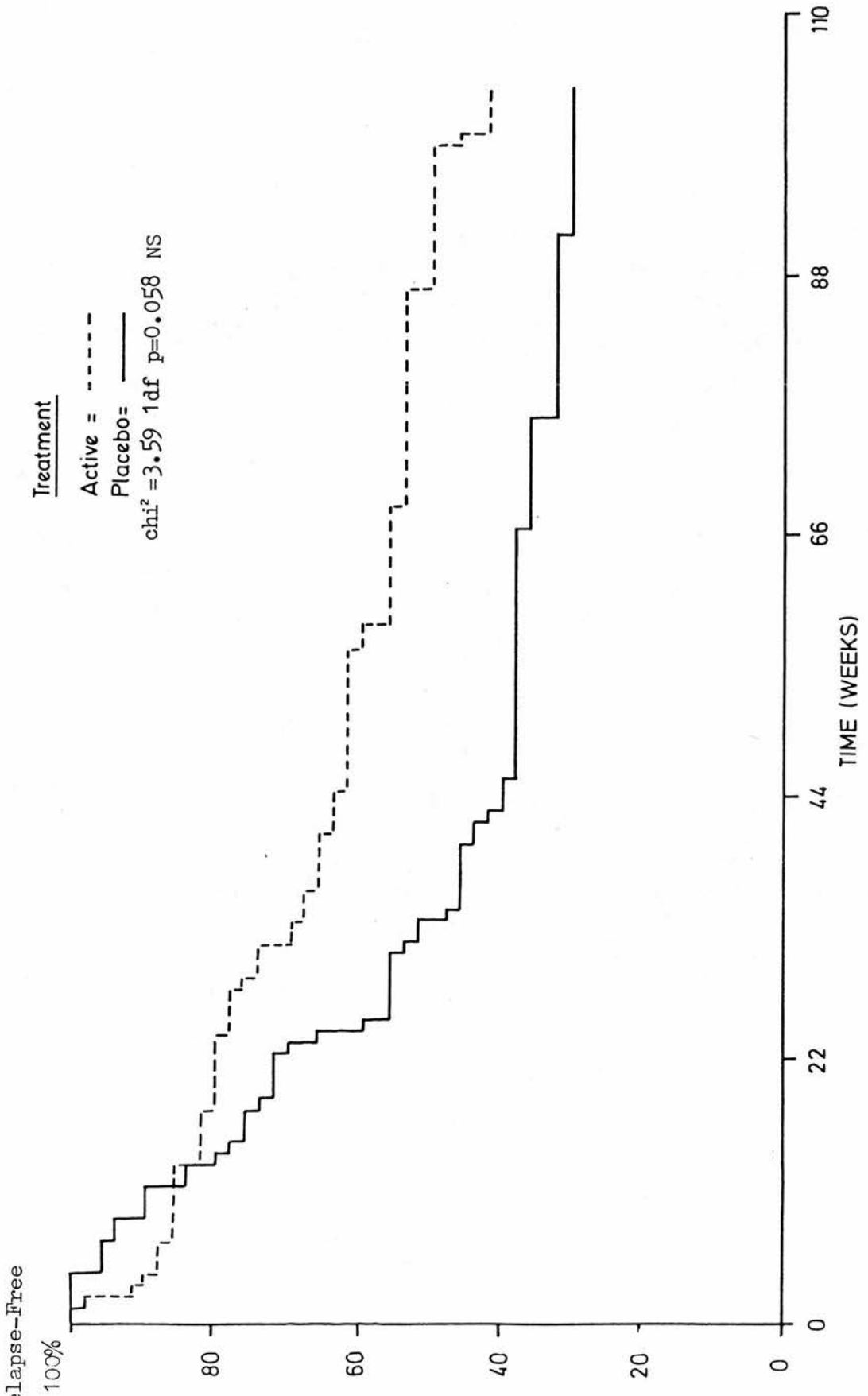

Relapse-Free
100%
80
60
40
20
0
All patients
0
22
44
66
88
110
TIME (WEEKS)

Graph 5.1

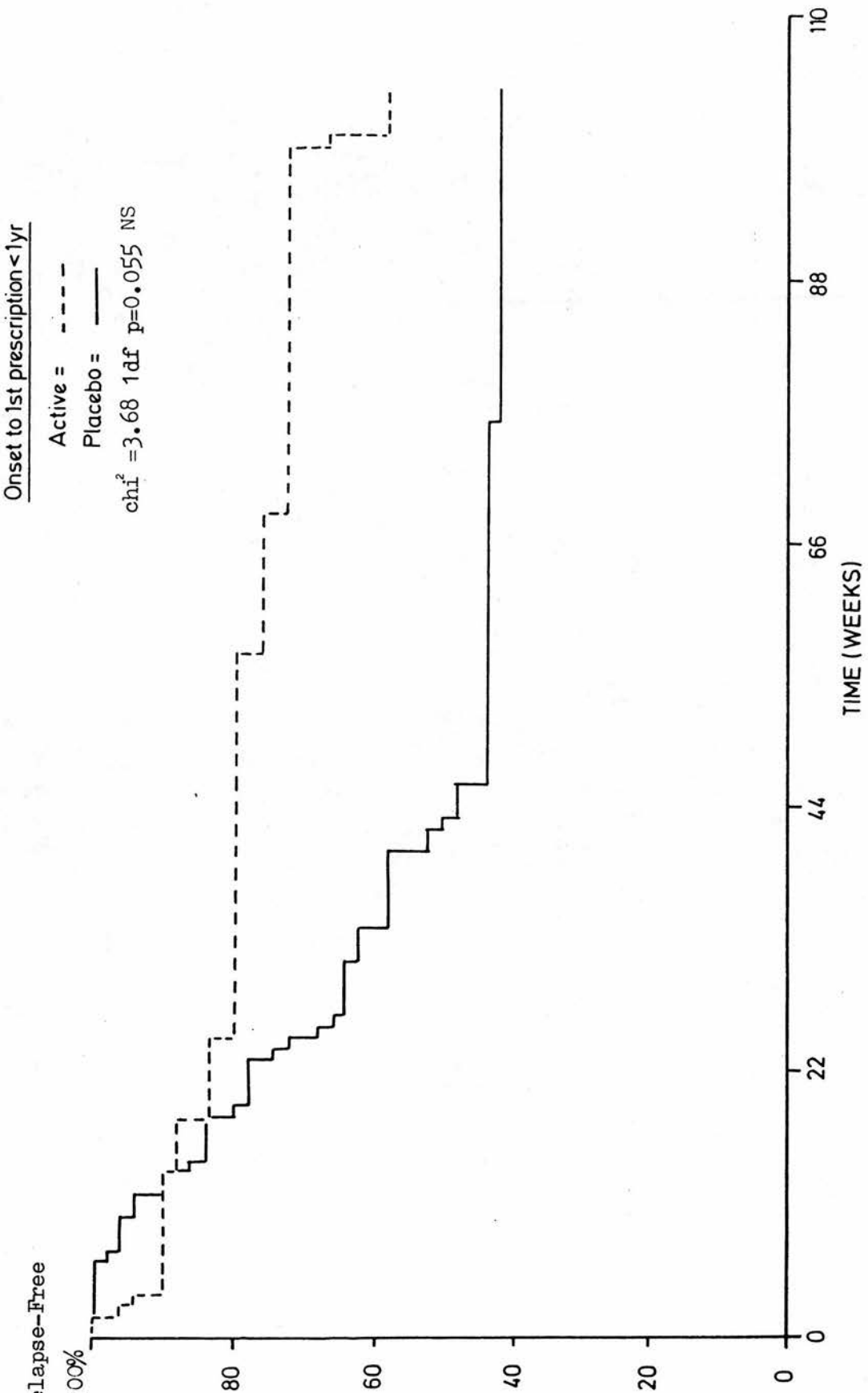
Graph 5.2

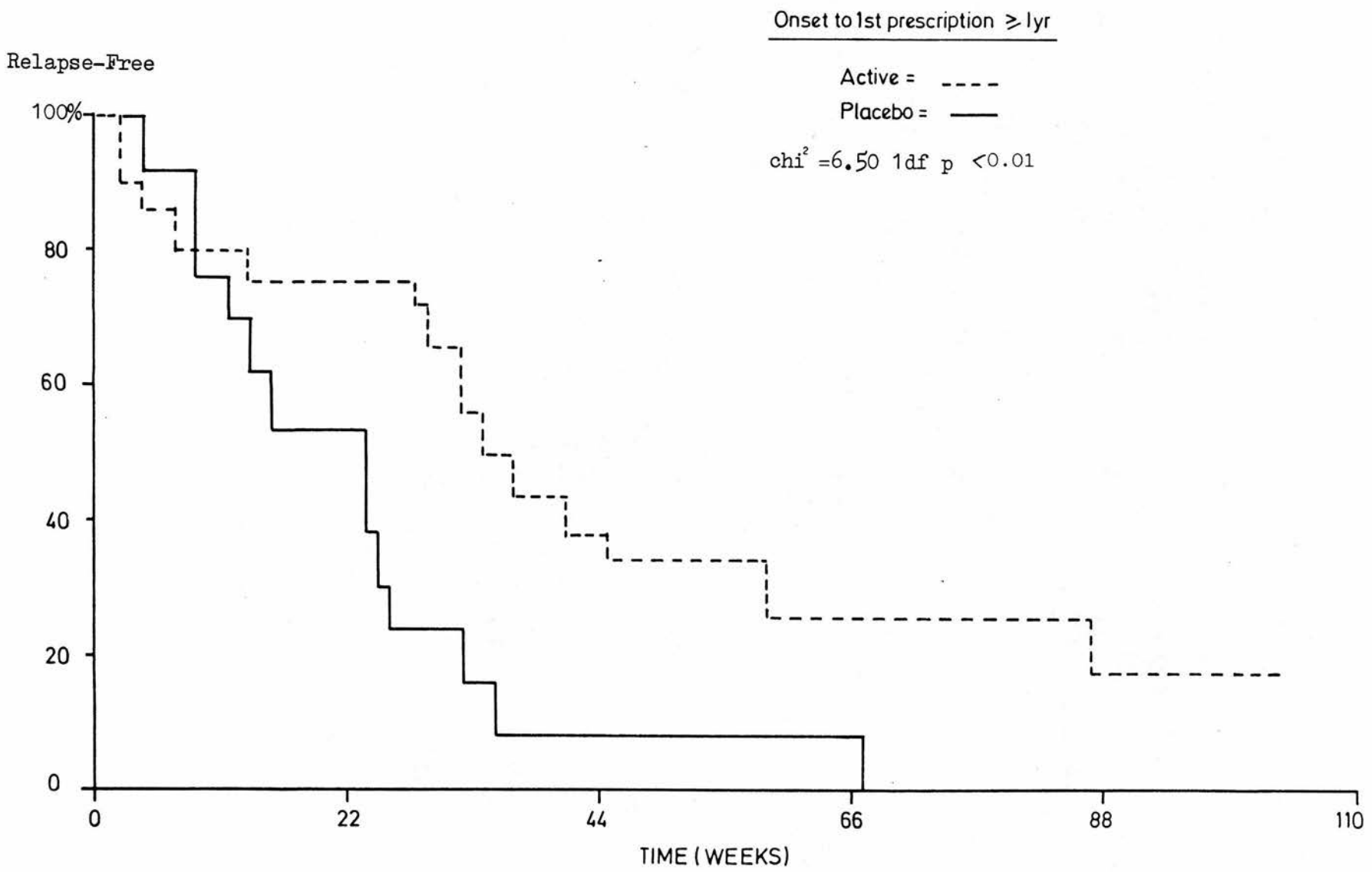

Onset → 1st Prescription
< 1 year = ----
≥ 1 year = ——
chi² =16.54 1df p <0.0001
Relapse-Free
100%
80
60
40
20
0
0
22
44
66
88
TIME (WEEKS)

Graph 5.3


Relapse-Free
100%
80
60
40
20
0
0
22
44
66
88
110
TIME (WEEKS)
Treatment
Active = - - - - -
Placebo= ——
chi² =3.59 1df p=0.058 NS

Graph 5.4


Onset to 1st prescription < 1yr
Active = - - - -
Placebo = ——
chi² = 3.68 1df p=0.055 NS
Relapse-Free
100%
80
60
40
20
0
0
22
44
66
88
110
TIME (WEEKS)


Onset to 1st prescription ≥ 1yr
Active = ----
Placebo = ——
chi² =6.50 1df p <0.01
Relapse-Free
100%
80
60
40
20
0
0
22
44
66
88
110
TIME (WEEKS)

Graph 5.5

CHAPTER VI

Prognostic Factors for the 235 discharged cases of 1st episodes of Schizophrenia in relation to relapse/readmision

Introduction

The study of prophylactic neuroleptic medication involving 120 cases yielded information not only concerning the benefit of medication in preventing relapse but also indications that a prolonged duration of illness is indicative of a high risk of relapse. For the examination of prognostic factors 120 cases is a relatively small number. Thus information concerning the outcome of the 116 cases, who whilst achieving discharge did not enter the double blind drug trial, was collected to enable a larger sample to be examined. Patients who participate in research projects such as a drug trial may differ from the population they are drawn from in many ways. It is of interest that reasons for participation may parallel reasons for nonparticipation. Some patients participated in the spoken hope of receiving placebo medication, some patients refused because they did not wish this. Within the group of patients (Trial Eligible) who did not participate were those who achieved a poor remission and four who were considered to be too well to need longterm prophylaxis. Hence the use of an additional 116 cases both increases the total sample size, and is more representative of cases of 1st episodes of schizophrenia.

Materials and Methods

The conduct of the prophylactic drug trial, the nature of follow-up and relapse have been discussed.

The outcome for the 116 trial eligible cases is considered here

solely in terms of readmission, which was considered to be the best available parallel to relapse in the trial participants.

Information as to readmission was gleaned from case note examination and personal contact with the patient, relatives and members of the caring professions. This data was collected as the study closed, and thus the time period covered was until readmission for a maximum of two years, or until 30 August 1982, or until loss of contact.

The medication received by these cases during this period was considered as 'standard treatment'. The information was too anecdotal to be further considered, but generally involved prophylactic neuroleptic medication.

The Patients

Sociodemographic and clinical details of the trial participants and the trial eligible cases are tabulated. The patients who did not achieve discharge (17 in all) are not considered.

The major difference between the two groups lies in relation to employment after discharge, in which the trial entrants do significantly better. (Table 6.1)

TABLE 6.1

Baseline Variables for Trial Entrants and Trial Eligible Groups

Variable	Classification	Trial Entrant	Trial Eligible	
Sex	Male	74	65	
	Female	46	51	
Ethnic Origin	White European	83	70	
	West Indian Negro	16	22	
	African Negro	3	9	
	Asian	14	11	
	Chinese/mixed	4	4	
Mother Tongue	English	95	97	
	European	8	5	
	Indian language	12	10	
	Chinese/Other	5	4	
Place of Discharge	Home	112	102	
	Hostel	8	6	
	N/K	0	8	
Employment (return to at Dischar)	Employed	43	13	
	Unemployed	72	72	$p<0.001$
	Day Centre	3	12	
	Student/Hwife/NK	2	19	
Period between Assessment	<2/12	42	27	
	2-6	31	29	
	6-12	13	10	
	>1 yr	31	25	
	N/K	3	25	

TABLE 6.1 cont.

Variable	Classification	Trial Entt	Trial Eligible	
Duration of hospitalis-ation	<14 days	3	11	
	15-30 days	14	24	
	1 - 2 months	46	25	
	2 - 3 months	22	13	
	3 - 6 months	24	30	
	>6 months	11	13	
Age at Discharge	15-19	15	15	
	20-24	38	40	
	25-29	21	23	
	30-34	10	14	
	35-39	18	6	
	40-44	10	10	
	45+	8	8	
PSE Major Class-ification	S+	94	96	
	P+	17	8	
	P?	2	6	
	0+	1	1	
	0?	0	5	
	D	6	0	
Year of admission	1979	28	17	
	1980	59	51	
	1981	33	48	
Period between onset and discharge	<1 yr	80	58	
	>1 yr	37	33	NS
	N/K	3	25	

Results

These are displayed as follows:

a) readmission for the trial eligible cases.

b) statistical comparisons of trial entrant and trial eligible relapse/ readmission rates by baseline variables.

c) examination of prognostic factors.

a) Relapse / readmission for trial entrants and trial eligible

The categories of relapse and the details of these have been described for the trial entrants. They are listed below for comparison with the trial eligible patients.

Trial Participants		Trial Eligible	
1. Relapse free at 2 yrs or close of follow-up	41	1. Readmission free at 2 yrs or close of follow-up	16
2. Relapse free but incomplete follow-up	13	2. Readmision free but incomplete follow-up	67
3. Relapsed	66	3. Readmitted	33
Total	120	Total	116

28.4% of the trial eligible cases were readmitted. The duration of contact and the reasons for loss of contact for the 67 trial eligible cases are listed below.

67 Trial Eligible Cases: lost contact

Patient No	Duration Follow-up	
002	1/7	Left area
028	17/12	Abroad
033	11/12	Patient declined
039	13/12	Abroad
058	1/52	Abroad
082	5/52	Patient declined
095	3/12	Patient declined
096	1/7	To Ireland
116	8/12	Staff changed in hostel
135	17/12	Patient declined
137	6/12	Discharged from base hospital
139	1/12	Left hostel, untraced
146	21/12	Mother unwell, contact lost
148	19/12	Patient declined
150	17/12	Discharged from base hospital
156	10/12	Family difficulty, contact lost
157	10/12	Discharged from base hospital
159	8/12	Patient declined
161	14/12	Patient declined
165	12/12	Patient declined
168	4/12	Patient declined
170	10/12	Patient declined
173	1/7	To Ireland
175	13/12	Discharged from base hospital
185	18/12	Relative declined
194	2/12	Patient declined

Patient No	Duration Follow-up	
196	16/12	Discharged from base hospital
200	15/12	Mother declined
202	17/12	Returned to South England
203	12/12	Discharged from base hospital
205	4/12	Abroad
207	2/12	Abroad
208	1/7	Patient Declined
210	16/12	Lost hospital contact
218	8/12	Relative declined
219	7/12	Left hostel untraced
223	10/12	Relative declined
227	8/12	Lost hospital contact
230	15/12	Lost hospital contact
240	10/12	Lost hospital contact
243	12/12	Discharged from base hospital
255	1/7	Left area, not traced
259	3/12	Social problems contact lost
264	1/7	Abroad
275	11/7	Patient declined
281	9/12	Patient declined
290	8/12	Patient transfered care
299	9/12	Last known contact with mother
311	8/12	Last known contact with mother
315	8/12	Discharged from base hospital
320	9/12	Family request: contact lost
331	1/7	Abroad
333	1/7	Left area

Patient No	Duration Follow-up	
336	1/7	Abroad
338	1/7	Untraced
345	3/12	To Europe
346	6/12	Last known outpatient contact
351	6/12	Last known outpatient contact
354	6/12	Left area
367	3/12	To Africa
369	5/12	Relative refused further contact
374	1/52	Patient declined
502	1/7	Entered private care
512	10/12	Last known outpatient contact
572	1/7	Not traced
589	2/52	Returned to Singapore
614	3/52	Untraced

The duration between discharge and loss of contact, completion of follow- up or readmission was calculated for each patient to the nearest week. Actuarial % readmission free were calculated weekly, and the resulting curves of readmission free were used for comparison with the active and placebo trial participants and the available data of baseline variables were similarly prepared for comparison.

The total duration of illness (onset to discharge or trial entry) was noted to have a large effect upon relapse rates in the Trial Entrants, with a brief total duration of illness being associated with a better outlook. This effect appears to be reversed in the Trial Eligible cases when readmission is considered,

those cases with a prolonged period of illness in excess of one year being readmitted less frequently than those with a briefer illness period.

Status of Trial Eligible Cases at Close of Study Examined by Period of Illness

	Readmission Free			Readmitted
	Discharge	Complete/incomplete		
Period of illness <1yr	58	10	27	21
Period of illness >1yr	33	4	23	6
Not known	25	2	17	6
All cases	116	16	67	33

The actuarial percentages readmission free were calculated for 6 monthly intervals for the Trial Eligible Group.

Trial Eligible Cases

Actual % Readmission-free at Months (standard error)

	6	12	18	24
Illness <1yr	63(7)	60(7)	48	48
Illness >1yr	87(6)	77(9)	77	77
Not known	70(11)	70	70	0
All cases	72(5)	67(5)	60(6)	54

(Standard error given when no. of cases at risk exceeds 10)

Contact was lost before the completion of follow-up in 67 cases (57.8%). An excess of these cases were drawn from the group with a period between onset and discharge equal to or greater than one year (69.7% of these with illness >1yr) as opposed to those with a briefer total illness (46.7% of those with illness <1yr).

Although readmission was the best parallel to relapse in the trial participants, being readmission free cannot be equated with well being in this Trial Eligible Group, and the criteria for readmision are unknown.

b) Comparison of Trial Participants and Trial Eligible Patients in Terms of Relapse

The status of all cases at the close of the study separated into treatment groups (active, placebo and standard) and divided by the period of time between onset and discharge is shown in Table 6.2. The actuarial % readmission free curves for the Trial Eligible population were used for comparison with the the Trial Entrants, and for comparison across other variables.

TABLE 6.2

Status of all cases at conclusion of study

Maintenance Treatment	Entered/ discharged	Relapse/Readmision Free: Complete follow-up	Relapse/Readmision Free: Incomplete follow-up	Relapsed/ Readmitted
Period of illness <1yr				
Eligible (standard)	58	10	27	21
Active	31	18	3	10
Placebo	49	18	6	25
Subtotal	138	46	36	56
Period of illness >1yr				
Eligible (standard)	33	4	23	6
Active	22	5	2	15
Placebo	15	0	1	14
Subtotal	70	9	26	35
Not known				
Eligible (standard)	25	2	17	6
Active	1	0	1	0
Placebo	2	0	0	2
Subtotal	28	2	18	8
All Cases				
Eligible (standard)	116	16	67	33
Active	54	23	6	25
Placebo	66	18	7	41
TOTAL	236	57	80	99

The relapse rate was compared using the log rank test for Trial Eligible versus Trial Active versus Trial Placebo groups (Peto et al., 1977). The curves for the three groups are shown [graph 6.1].

The difference in treatment regime is statistically significant, with placebo maintained patients experiencing more relapse. Trial Active and Trial Eligible patients experience very similar rates of relapse and readmission. Examination of other baseline variables indicates that Trial Placebo experience more relapse than Trial Active and Trial Eligible Patients, which are broadly similar in outcome. Comparisons of baseline variables within the treatment groups (shown in Table 6.3) were examined to see if these accounted for the similar rates of relapse in the Trial Active patients and readmission in the Trial Eligible cases.

TABLE 6.3

Comparison of Trial Active/Trial Placebo/Trial Eligible

Relapse/Readmission occurrence by baseline variables

Variable	120 Trial Entrants Placebo v Active	120 Trial Entrants & 116 Trial Eligible Placebo v Active/Standard
1) Maintenance Therapy	PvA p=0.058 NS	PvA/S p<0.004
The following variables: with	Not adjusted for treatment	Adjusted for treatment status
2) Sex Male v Female	NS	NS
3) Ethnic Origin White European v Others	NS	NS
4) Mother Tongue English v Others	NS	NS
5) Period between onset and discharge/trial entry <1yr v >1yr	p <0.001 >1yr excess relapse	p=0.17 NS >1yr excess relapse in placebo treated
	no difference between active & standard	
6) Place of discharge home v hostel	NS	p <0.05 hostel excess relapse/readmission
7) Employment at discharge/trial entry	p <0.001	p <0.0001(200 cases) employment/less relapse/readmission

TABLE 6.3 cont..

Variable	120 Trial Entrants Placebo v Active	120 Trial Entrant & 116 Trial Eligible Placebo v Active / Standard
Age at discharge 15-24/25-29/30+	NS	NS
Time in hospital Admission to 1st trial prescription: <6/12 v >6/12	NS	-
Period of hospitalisation <1mth/1-3mth/ >3months	NS	NS

None of the baseline variables accounted for the similarity in the relapse/readmission rates for trial active and trial eligible, or for the excess relapse in the placebo group, which was thus explicable only in terms of the nature of the prophylactic treatment.

This establishes the similarity in outcome for the Trial Eligible cases on Standard Treatment to the Trial Active Treatment, and the excess of relapse in the placebo treated cases, which seems related to the nature of the prophylactic treatment only.

c) Prognostic Factors

Thus prognostic factors were examined using first:

1) The Trial Entrants

2) The Trial Entrants and the Trial Eligible

The difficulties posed by the small number of selected cases in the Trial Entrants are overcome by using the Trial Eligible group. However, the relatively large number of cases where contact was lost and the use of readmission as a parallel to relapse may give rise to other errors. Hence sets of results are presented within the Trial Entrant group (adjusted values accounting for active and placebo medication are made) and within the Trial Entrants and Trial Eligible groups (the treatment is accounted for by examining the placebo maintained group, and the active/standard group considered together, and adjusting for treatment between these two groups.) The actuarial % relapse/readmission free at six monthly intervals, covering the two years of follow-up are shown in Table 6.5. The cases are divided in trial eligible, trial active, and trial placebo, and also divided by the total duration of illness (period between onset and discharge or trial entry.

TABLE 6.5

Maintenance Treatment	Actuarial % Relapse/readmission free (standard error) at months			
	6	12	18	24
Period illness <1yr				
Eligible (standard)	63(7)	60(7)	48	48
Active	80(7)	80(7)	71(9)	57
Placebo	70(7)	46(8)	43(8)	43
Subtotal	70(4)	60(5)	52(5)	48(5)
Period illness >1yr				
Eligible (standard)	87(6)	77(9)	77	77
Active	76(9)	33	26	18
Placebo	30	0	0	0
Subtotal	71(6)	44(7)	38	30
Not known				
Eligible (standard)	70(11)	70	70	0
Active	0	0	0	0
Placebo	0	0	0	0
Subtotal	69(11)	69(11)	69	0
All cases				
Eligible (standard	75(2)	67(5)	60(6)	54
Active	79(6)	61(7)	53(8)	42
Placebo	60(6)	37(6)	33(6)	30
TOTAL	70(3)	56(4)	49(4)	42(5)

(Standard error given when number of cases at risk exceeds 10)

Prognostic factors were examined, with the results tabulated in Table 6.6.

TABLE 6.6

Prognostic factors drawn from the assessments

Factor	(120) Trial Entrants	(170) Active/Standard and Placebo (66)
Social Withdrawal	NS(83)	NS(127)
Within placebo group only; $p<0.05$; more withdrawal gives more relapse		
Change in social withdrawal over preceding year	NS(78)	NS(121)
Within active/standard group only $p<0.05$ more withdrawal change gives more relapse		
Nature of onset of illness	$p<0.01$(99) insidious - more relapse	NS(154)
Occupational data		
peak career	NS(103)	NS(152)
recent career	NS(104)	NS(152)
Illness in household		
none v psychiatric v physical	$p<0.03$(103)	NS(169)

Summary of Results

Within the small group of 120 trial entrants the period between onset and trial entry showed a very significant relationship to relapse. This relationship did not recur when readmission was related to the total period of illness in the trial eligible patients only, but in a large number of these patients follow up was incomplete. Return to employment in all treatment groups was associated with a better outlook than return to unemployment at discharge. Age at discharge and the duration of hospitalisation had no significant effect upon relapse, but discharge to home rather than a hostel was significantly associated with a lower relapse/ readmission rate.

The nature of the onset of the illness was divided into acute (less than 7 days) subacute (7-28 days) and insidious (>30 days). An insidious onset was related to increased relapse in the trial entrants, but had no significant effect when the trial eligible cases and their readmissions were considered. An effect seen in trial entrants, but not in the total 236 discharged cases, was of the presence of psychiatric or physical illness in the household, which thus appeared related to relapse but not to readmission.

Social withdrawal has been demonstrated as a predictor of outcome previously (Stephens, 1978), but within this sample, the interpretation of the results is problematic. Social withdrawal assessed on the basis of accounts from relatives for the month preceeding admission had a significant relationship with relapse in the placebo treated group. The greater the withdrawal the greater the relapse in the placebo maintained group. This group contains 51 out of 66 cases who have a period of total illness of less than 1

year. Thus when change in social withdrawal over the preceding year is considered one might expect within the placebo group, cases which show any change, to have done so rapidly. These cases have a lower relapse risk by virtue of the relative brevity of their illness, and thus change in social withdrawal in the placebo group is not associated with an increased risk of relapse, but severity of withdrawal is in the placebo maintained group, related to more relapse. Within the active and standard group, however, the more change that has occurred in the preceding year in the severity of social withdrawal, the greater the relapse risk.

It is not feasible here to separate out the elements of abnormal social behaviour and the lapse of time. In the larger group of trial active and trial eligible patients, the change in social withdrawal may be a marker of serious illness rather than of acute onset, as it is in the placebo group.

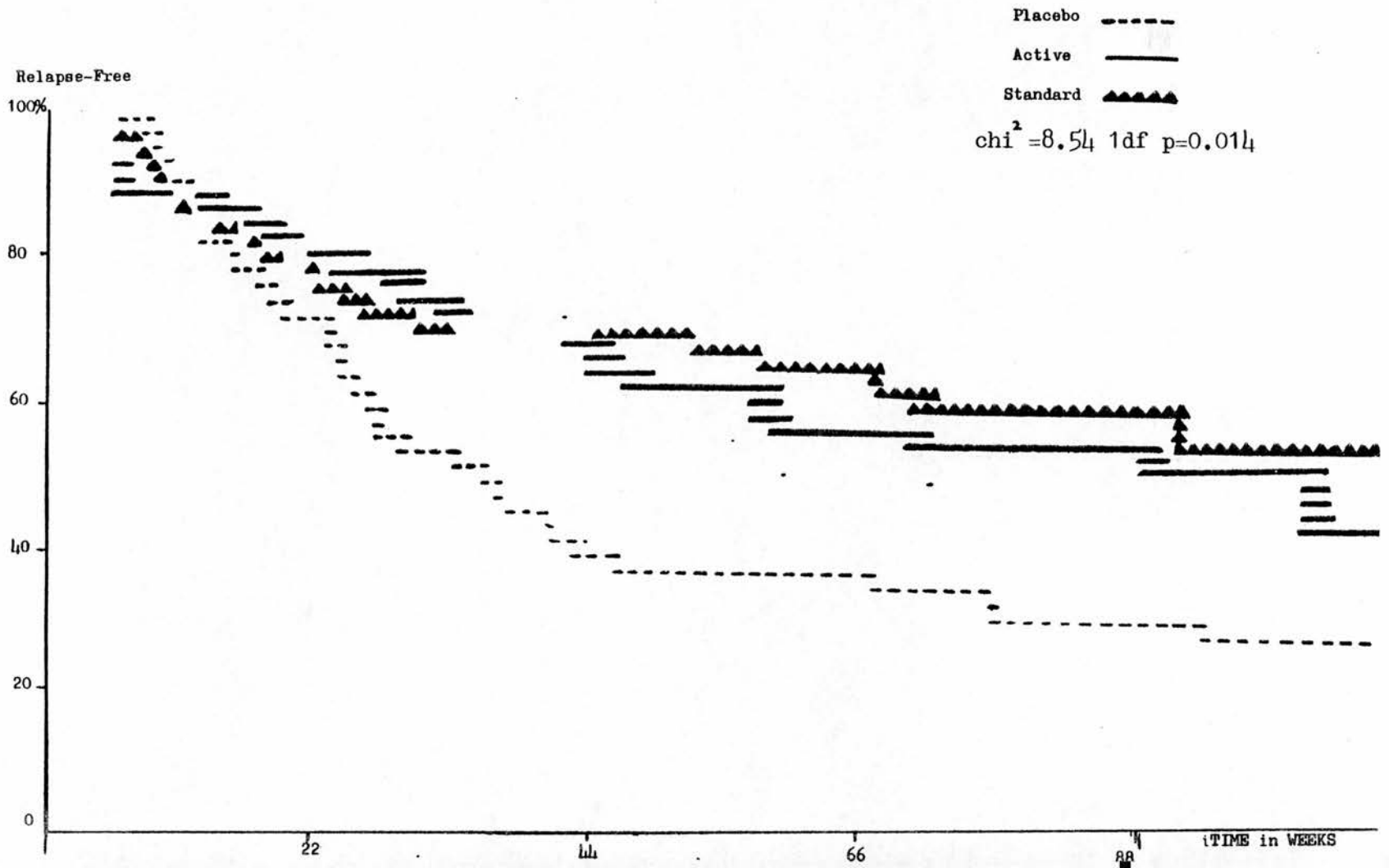
Such effects as were demonstrated paled in the face of the effects of time; significant at the $p < 0.0001$ (trial cases) level where time of illness is divided at one year, and treatment, which when adjusted for period of illness, is significant at the $p < 0.005$ level (all cases).

It was not possible to statistically demonstrate an effect of age or sex. The effect of prophylactic treatment persisted when these variables were accounted for, and when elements of the passage of time were accounted.

The relationship between the nature of the home environment and relapse/readmission, and the effect of disturbed behaviour preceding the first admission are discussed in Chapter IX.

It is of interest that in this sample of first episode

patients, prophylactic treatment is the major influence upon relapse/readmission, and time the major variable affecting relapse. Schwartz demonstrated this relationship between prophylaxis and readmission, and, even at this early stage of the illness, with a brief duration of follow-up, this is true for the sample.


Placebo
Active
Standard
chi² =8.54 1df p=0.014
Relapse-Free
100%
80
60
40
20
0
22
44
66
88
TIME in WEEKS

Graph 6.1

CHAPTER VII

THE SHORT TERM OUTCOME

Introduction

253 patients with a clinical diagnosis of schizophrenia supported by a Present State Examination had come to admission to one of 10 different hospitals for investigation and treatment of first psychotic illness. The length of contact with the patients varied from days to two years and the detail of the information gained was dependent upon the accessibility and co- operation of patients and their families. The outcome is considered in terms of the hospital careers of the sample, and in terms of social factors such as employment, marriage and childcare. Reference will be made to differences between the trial entrant population (120) and the trial eligible population (133) of patients.

The Hospital Careers

The hospital careers of patients concern information relevant to the index admission, readmission, and total hospitalisation during the follow up period.

Index Admission

The length of the index admission was calculated on the basis of the number of hospitalised days, disregarding weekend and day leave, from the index admission day to that date of discharge which was successfully followed by 30 days or more free of rehospitalisation.

The index admission was considered to have been successfully concluded only when the patient achieved a thirty day period free from hospitalisation following discharge. Thus, if a discharged patient came to readmission within 30 days this was considered as an extension of the index admission. This policy was derived from the design of the drug trial, in which all patients received active medication for the first month following discharge. Hence 120 patients, within the drug trial study, were not considered to have entered the trial successfully until 30 days after discharge.

This method of calculation underestimates readmissions, as those patients who were repeatedly discharged and rapidly readmitted during their index hospitalisation will have been considered to have only one admission during this period. It does, however, give a more realistic concept of the duration of the index hospitalisation. Attendance at day hospitals, which formed an integral part of the base hospital, is considered as part of the index admission.

Table 7.1 denotes the duration of the index admission calculated on the basis described above. In these terms there is no substantial difference between trial entrants and trial eligible patients, barring those who did not achieve discharge.

TABLE 7.1

Duration of Index Admission

Days Duration of Index Admission	Total Patients	Trial	Trial Eligible
= <30	59	27	32
31 - 60	63	35	28
61 - 90	39	22	17
91 - 120	19	12	7
121 - 150	18	6	12
151 - 180	17	8	9
181 - 230	13	5	8
231 - 300	6	4	2
301 - 360	1	1	0
361 - 480	2	-	2
481 - 600+	1	-	1
Not discharged	13	-	13
Unascertained	2	-	2
	253	120	133

Table 7.2 examines the data with reference to the base hospitals, separating the patients into three arbitrary groups of brief, medium and protracted admissions. Patients who did not achieve discharge by the close of the study and repatriated patients

are tabulated separately.

TABLE 7.2

Length of Index Admission by Base Hospital

	Nos of Patients									
	Hill End	Naps	NPH	L&D	Shen	StM's	Friern	StB	Whitt	Totals
Brief										
<30 days	1	2	8	15	21	6	2	3	-	58
Medium										
1-6/12	11	1	32	28	42	6	9	2	6	137
Protracted										
>6/12	2	2	9	4	8	5	4	5	3	42
Not discharged	-	-	3	2	5	-	2	1	-	13
Repatriated	-	-	1	-	-	2	-	-	-	3
Totals	14	5	52	49	76	17	17	11	9	253
Use of										
Hostel	-	1	2	2	4	3	2	-	1	
Day Centre	1	-	1	-	-	2	-	-	-	

The base hospitals operated a range of admission and discharge policies. Hill End Hospital, serving a widely spread rural community, used a policy of long admission in contrast to Napsbury Hospital where crisis intervention and community services were emphasised in preference to admission. Despite this difference in approach, these hospitals, and all other base hospitals, had some patients who received inpatient hospital care for longer than six months. Whilst the early discharge of patients treated at Napsbury reflects hospital policy, the tendency towards early discharge at Shenley Hospital and St Mary's Hospital could well reflect the loose structure of the catchment area population.

Four patients attended day centres outwith the hospital setting, subsequent to discharge, and 15 patients were discharged to hostel accommodation. The single patient at Hill End Hospital, who had a brief admission, attended a day centre for the following two years. In all other cases, hostels and day care placement were utilised by patients who had protracted index admissions.

Immediately after discharge two patients left for their country of origin and eight patients were lost to further contact. The social circumstances at discharge are tabulated below. It may be that some patients ostensibly returning home, did not do so.

At Discharge/Close of Study	Total	Trial	Trial Eligible
Absconded, lost contact	8		8
Not discharged	13		13
Repatriated	5		5
Entered private care	1		1
Hostel placement	15	8	7
Day care (without hostel)	13	3	10
Home (no day care)	198	109	89
	253	120	133

The duration of hospitalisation, at the close of the study, for the thirteen undischarged patients is shown below.

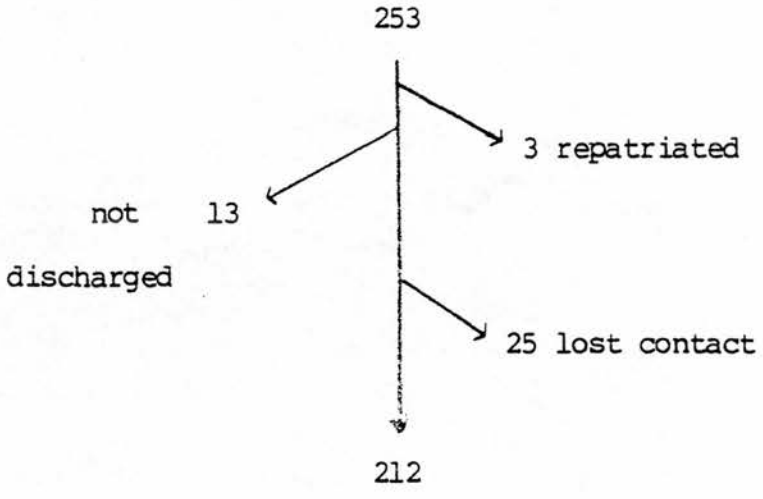
Non Discharged Patients

Duration	Nos of Patients
2 years	3
18/12	1
14/12	1
12/12	1
8/12	2
6/12	2
5/12	2
4/12	1
Total	13

Readmission

Although relapse was noted in patients participating in the trial, only recorded readmission as a day patient or an inpatient is considered here. The index admission was required to be followed by a thirty day period free of hospitalisation; thereafter, all recorded readmissions at any interval are counted. When patients who failed to achieve discharge, repatriated patients, and patients with whom contact was lost in less than six months follow up are discounted, 212 patients are left for consideration.

Patient Sample considered in Readmission Data



The limited information available on those with whom contact was lost is presented as follows.

002 Medium Admission. Left area within 1/12; untraced.

018 Medium Admission. Readmitted at 31 days. Returned to Nigeria at 2/12.

052 Medium Admission. Refused further contact. Not readmitted locally in 1 yr.

058 Medium Admission. Absconded to Europe. Returned to Britain, thence to parental home USA, all within 3/12.

082 Medium Admission. Refused all contact at 1/12.

095 Medium Admission. 4/12 follow up post discharge; no relapse.

096 Absconded to Ireland from inpatient care. Contact lost.

139 Protracted admission, hostel placement. Left hostel suddenly at 1/12. Contact lost.

143 Absconded from inpatient care at 20 days.

173 Absconded to Ireland from inpatient care at 15 days.

194 Took early self discharge; attended OPD for 2/12, then refused contact.

208 Transferred to another hospital; inpatient care for four months. Hostel placement underway, contact lost.

230 Absconded from inpatient care at 3 days.

255 Refused all follow up after four months day hospital attendance. Positive psychotic features, but employed at that time.

275 Date of discharge unknown. In hostel 5/12 after index admission.

309 Medium admission. Refused all contact after discharge.

330 Protracted admission. Left for Europe on day of discharge.

331 Medium admission. Returned to West Africa two months later.

359 Charged with theft after brief admission. Contact lost at 3/12.

367 Returned to Ghana 3/12 after brief admission.

369 At home 3/12 after brief admission at close of study.

374 Took self discharge at 35 days and refused all contact.

502 Entered private care, contact lost.

572 Contact lost after medium admission. ?Went abroad.

614 Self discharge at 21 days; contact lost at 4/12.

Repatriated Patients

264 Repatriated at 21 days (West Indies)

336 Repatriated at 18 days (Malaysia)

589 Repatriated at two months following discharge (Singapore).

Readmission data is tabulated.

TABLE 7.3

Readmission by Duration of Follow Up

Duration of follow up	Readmissions 0	1	2	3	4+	Total Pts	Total Read	% Read
6 - 12 months	28	6	1	-	-	35	7	20
12 - 18 months	43	13	1	2	3	61	19	31
19 months - 2 years	71	25	13	3	3	115	44	38
Totals	142	44	15	5	6	212	70	33

Of the 212 patients available to follow up for six months or longer, 70 patients were readmitted, and after eighteen months follow-up, readmission, not unexpectedly, continues to occur.

TABLE 7.4

Readmission by Duration of Index Admission

Duration of Index Admission	Total Nos Patients	Lost Contact Nos Patients	Patients Available	Patients Readmitted
= 30	59	8	51	19
31 - 60	63	11	52	11
61 - 90	39	3	36	11
91 - 120	19	0	19	6
121 - 150	18	1	17	9
151 - 180	17	1	16	7
181 - 230	13	1	12	3
231 - 300	6	0	6	3
301 - 360	1	0	1	1
361 - 480	2	0	2	0
481 - 600+	1	0	1	0
Not discharged		13		-
Index not ascertained		2		0
Repatriated		3		-

The very variable duration of hospitalisation and of follow up makes interpretation of the readmission data, based upon the calculated duration of the index admission, complicated. The nineteen patients who came to readmission after an index admission of less than 30 days did so after at least 30 days free of

hospitalisation, and this relatively large number of readmitted patients is not simply an artefact of rapid discharge and readmission.

Of the 142 patients who did not come to readmission a small number were continually supported in the community throughout the follow up period. Three patients continued to live in hostels during the follow up, one for one year, and two for two years. One patient attended day care for two years, and six patients for over a year. A further three patients had attended day care for six months at the close of follow up.

In summary, out of 253 patients, three patients were repatriated during their index admission and contact was lost over a period of less than six months in a further 25; thirteen others failed to achieve discharge at the close of the study all having been hospitalised for four months and some for over a year. A further thirteen patients received continuing outpatient support in hostels or day care, but avoided readmission. Seventy patients came to readmission, and 129 patients remained outside hospital for between six months and two years.

The outcome of this sample of first episode schizophrenic patients is widely variable in terms of duration of index hospitalisation and readmission.

Hospital Days

Graph 7.1 displays the total number of days spent in hospital by patients, expressed as a percentage of their duration of follow up. A large cluster of patients followed up for two years had spent less than 20% of those two years in a hospital setting. The 25 patients who were lost to follow up are not included in this graph, and the

two patients with unascertainable duration of index admission are discounted.

The lines on the graph denote the cut off between one month, and twelve months, and patients falling below these lines have experienced no more than this duration of hospital care. The graph clearly demonstrates wide variations in the length of hospitalisation experienced by this sample of patients.

Six of the patients followed up for two years have had less than one month in hospital, 48 have spent between one and six months in hospital, and ten patients between six months and a year. 12 patients followed up to two years have spent over a year in hospital.

Summary of Hospital Careers

The information gathered in relation to the hospital careers of this sample of patients provides an impressive variation from patient to patient, which to some extent overrides hospital policy. The bulk of the sample spent between one and six months in the index admission, but the index admission ranges from days to over six months across all base hospitals.

Some patients were transferred to hostel accommodation following discharge and some others attended day care for months or years, and a handful of patients failed to achieve discharge by the close of follow up. These patients constitute 10% of the total sample, despite this being their first hospital admission.

Information is very limited in 29 cases; these are discounted. Half of the remaining patients came to readmission within the two years following the index admission day, some patients repeatedly so.

Employment

The main occupation of the patient was noted at admission, employment, unemployment, full time study or housecare were considered as separate categories.

Employment status required that the patient had held continuous employment for one month or longer, in the open market.

The overall figures for occupation at admission, discharge and follow up are presented.

TABLE 7.5

	At Admission	At Discharge	At Close Follow Up
CATEGORY	TOTAL	TOTAL	TOTAL
Full Time Employment	100	63	62
Males	67	47	45
Females	33	16	17
Full Time Housewives	30	25	22
Full Time Students	21	8	5
Retired/Part Time Work	4	9	11
Unemployed	95	111	87
Males	62	67	40
Females	33	44	47
Uncertain	3	4	-
Lost Contact	-	23	35
Not Discharged	-	13	13
Irregular Employment	-	-	11
Judicial/Dead	-	-	7
TOTAL	253	253	253

The consideration of employed and unemployed patients is complicated by female patients ceasing employment to become full time housewives, and by the loss of employment in the months leading to admission.

At admission, 67 male patients were employed, in occupations ranging from the professional (dentistry, pharmacy) to unskilled labouring. 42 patients returned to their previous employment at discharge, but four patients left and were then intermittently employed; one other patient entered judicial care. Of the 67 employed males, 37 remained in their previous work at the close of the study, and two remained off sick, their employment held open for them. Nine patients entered new employment, two immediately on discharge and seven at variable points during follow up. Six of these nine patients had held employment at admission. Three patients gained employment from unemployment at admission. One was a post-graduate PhD student with a long history of abnormal behaviour, and one a seafarer suffering an acute illness during a period of unemployment; the third patient, a farmer from Ireland, was found a labouring job by his caring sibling.

Contact was lost with six of the 62 unemployed patients, five patients failed to achieve discharge, and the three patients described above gained employment. Of the 49 remaining patients of this group only three attained irregular unskilled employment. Two of the four deaths occurred in this group.

The female patients classed as employed or unemployed fared in a similar fashion. One patient with a puerperal illness became a full time housewife. Four patients, two employed and two unemployed, failed to achieve discharge. Contact was lost in

eight cases. Eleven patients lost their employment; seven failed to regain employment, although three succeeded, and one patient worked intermittently. Only one patient who was unemployed at admission gained full employment, but lost it when she relapsed. Two patients achieved part time work, one in her previous occupation (bank clerk) and one who had been unemployed at admission, a middle aged woman who had previously held similar domestic posts.

The overall figures presented below include a note on patients who had held employment within the twelve months preceding admission. The decline in employment subsequent to admission and the relative lack of resolution of the situation during the follow up period is matched by a marked fall in employment preceding admission.

Employed patients

Males		Females	Total Available	
81	12/12 preceding admission	51	253	
67	at admission	33	253	
47	at discharge	16	236	27 lost contact
45	at follow up	17	218	35 lost contact

These patients were examined between 1979 and 1982 when unemployment increased throughout the nation and notably in the young.

The figures displayed may be distorted by the cases with whom contact was lost. On the other hand, if one makes the bland assumption that all such patients are in employment the fall in employment occurring in the year preceding hospitalisation remains

striking.

Students

21 patients were engaged in full-time study at the time of admission, and a further four patients were engaged in night classes or day release courses.

The outcome for schoolchildren, undergraduates, postgraduates and other students is briefly described.

Six patients, two male and four female were at school at the time of admission. One girl was referred via the school services. Three of these students returned to school, between two months and fourteen months after the index admission. One patient had several readmissions and left for Eire, one patient remains disabled at a day centre, and one youth is now unemployed and at home, but in good health and no longer taking any medication.

Four patients were engaged in study at colleges of further education. One patient returned to West Africa shortly after discharge, one patient abandoned study and is in part time employment, one has successfully returned to his studies, and one female patient remains severely disabled by ongoing positive symptoms.

Of the five undergraduates, one of whom was engaged in private education, only one patient completed his studies. This youth is entirely symptom free and has retained an unimpaired personality. One male obtained qualifications in Optics, but has intermittent positive symptoms, another patient, suffering positive symptoms after two years follow up has gone abroad in search of a teaching post, and one patient successfully attends a polytechnic undertaking

studies well below his premorbid intellectual capacity. The patient engaged in private study returned to Africa, relapsed, and is now psychiatrically improved but unemployed at eighteen months follow up.

Contact was lost with three of the four postgraduate students. The fourth patient gained employment not out of keeping with his premorbid level of intelligence, he having previously been awarded a first class degree at an established University. He has resumed his postgraduate work but is aware and realistic about the constraints of full time employment.

The range of achievement is reiterated in the five other students. One apprenticed toolmaker completed his course making up for time spent in hospital, and came second in his year. He is now in full time employment, and has retained an unimpaired personality. A female patient has maintained full time employment and increased her secretarial skills at night classes and with correspondence courses, and passed ordinary level mathematics. She comes from a deprived social setting. Two trainees, one in hotel management, one in printing, left their studies and later relapsed. One eventually completed a Diploma of Education course post relapse, the other spent a long period in hospital when very severely disturbed, but rejoined a college, only to relapse. The fifth patient changed from training as a chartered accountant to training in quantity surveying, and has a mild defect.

In Summary

Contact was lost with five students. One undergraduate completed his studies and graduated. Four other patients obtained qualifications, two in keeping with their premorbid level, and two at a reduced level. All four are employed, and although one of them has had two relapses, he was able to avoid readmission to hospital. One postgraduate continues his old studies and has suitable employment, and three schoolchildren are completing their education. The eleven other students have not fulfilled their past potential, with the possible exception of one schoolboy who, although unemployed, is well and lives in an area where unemployment is not the prerogative of those with a psychiatric history.

Marriage and Child Care

The marital status and number of children of appropriate patients was noted at admission. During the course of the study the marital status of the sample shifted.

Admission	Status	Last available data
177	single	172
9	cohabiting	9
43	married	45
9	separated	10
12	divorced	13
3	widowed	4
253		253

Five patients married during the course of the study.

The marital arrangements of the two male patients were unusual. Patient 004 married a woman many years his senior, having met her in his capacity as a seafarer on a pleasure cruiser. The lady had

been previously married to a man who had displayed bizarre behaviour for years, and had finally taken his own life. Patient 283 married his fiance, of seventeen years standing, shortly after discharge from hospital.

Three male patients are known to have begun to cohabit on a stable basis during follow up, and two of these patients fathered pregnancies during the follow up period.

Married during the course of the study

No	Sex	Age	Details
004	M	39	Acute illness, leading to loss of cohabitee. Married 2 years after admission.
061	F	25	Acute illness, subsequent loss of employment. Met and married at 20/12; now fully employed.
075	F	24	Severe illness, residual defect. Married in face of family disapproval. Delivered healthy child, suffered exacerbation of symptoms which had recurred during pregnancy.
240	F	19	Marked defect after illness, but married fiance. Well at 2 years.
283	M	35	Acute episode after 2 years withdrawal from work and social events. Married fiance after 17 year engagement.

Cohabiting during the course of the study

No	Sex	Age	Details
019	M	21	Acute illness, remained well at 2 years. Partner pregnant at close of follow-up.
038	M	30	Unemployed graduate. Cohabiting, and partner pregnant at close of follow up. Healthy female child delivered post follow up.
146	M	29	Well after index admission. Moved in with girl-friend and her two children.

Failed Marital Arrangements

Two male patients did not enter into marriages already arranged for them, and neither did they marry during follow up. Five patients ceased to cohabit in relationships of long duration, although one of these patients married later (patient 004). Two marriages came to an end. One (patient 009) was an arranged marriage of a school aged patient, and ended in formal divorce. The other patient (207) separated legally from his wife, who presented her own long standing history of psychosis predating the marriage. One other male patient (203) who had married a few months prior to admission simply failed to ever return to the marital home. One male patient (049) murdered his wife whilst psychotic.*

It is possible, especially amongst the West Indian population that other arrangements, especially in terms of cohabitation, are unknown to the author. This is less likely amongst the population of patients who participated in the drug trial and with whom there was adequate contact.

* Patient 266 also murdered his wife whilst psychotic some months after follow-up formally closed.

Children and Child Care

63 patients from the group of 253 were known to have had offspring at the time of admission. Three female patients were delivered of children during the follow up period, giving a total of 119 progeny from sixty-six patients.

This figure may be an underestimate as the status of five patients concerning progeny remained unknown, and it is not possible to account for the illegitimate children of male patients.

Thirteen patients had a total of 33 adult offspring noted at admission. One patient had one adult son and one who was a minor. Allowing for births during follow up, fifty-three patients could have been expected to have care of 85 minors.

TABLE 7.6

Adult Offspring only of 13 patients		Minor Offspring of 53 patients	
Female	Male	Female	Male
pts 8	pts 5	pts 36	pts 17
22 adult progeny	11 adult progeny	50 minor progeny (+ 1 adult)	35 minor progeny

Patients with offspring over the age of 16 years

Of the five male patients with children over the age of 16 years, two patients lived in a family setting, and two were separated and living alone. The fifth patient had recently joined his children in Britain, and his wife joined them during the follow up period. One separated male patient lived with a son after his second admission, until suitable sheltered housing was found.

Eight female patients had adult offspring. Two of these patients lived with their spouses and children, and four lived alone. The seventh patient had her grandson living with her, an apparently successful arrangement, and the eighth patient had separated from her spouse some years previously and spent substantial periods in her own parental home. This patient regained contact, apparently by chance, with her only daughter who left home at the age of 16, and been out of touch for nearly two years. One patient (069) lived with her daughter for some months after discharge until she obtained residential employment.

Apart from brief periods of residence with family members the social contact as between these patients and their adult progeny was not substantially altered.

Adult Progeny

No	Sex	Age	No of Children	Details
021	F	52	2	Divorced. Adult children in contact, living abroad.
032	F	54	2	Divorced. Adult children local, in contact
069	F	57	3	Divorced twice. Adult children local, supportive
097	M	40	3	Married, adult children at home. One child has a psychiatric history.
123	M	40	2	Married. Joined children in UK, wife joined them later.
124	F	54	1	Divorced. Virtually no contact with only daughter.
125	M	59	3	Separated. Elder son very supportive.
150	M	42	2	Married, adult children within nuclear family.
165	F	65	9	Widowed. Children by two marriages. Eldest grandson lives with patient.
229	F	37	3	Married very young. Children at home in nuclear family.
329	F	39	1	Separated. Regained contact with runaway daughter at close of study.
350	F	56	1	Married. Son has long psychiatric history, at home in nuclear family.
022	M	39	1	Divorced. No contact
	13 (+1)		33 (+1)	*

* Patient 151 had one elder son who had left home previously, and one child who was a minor.

Patients with children who were minors

Fifty-two patients had produced eighty-four children who were still minors before and during the study. The outcome is considered for male and female patients separately.

Male Patients with Offspring who are Minors

TABLE 7.7

Care arrangements of 35 children of 17 male patients

	At Admission	At Close F/up
Living with single parent (patient)	1	0
Living with extended family	0	0
Living with nuclear family (both parents)	23	17
Child living with well parent (not patient)	11	15
Judicial or voluntary care	0	3
	35	35

Two (312, 217) of the seventeen male patients had left their partners some years prior to admission, although one (312) maintained regular contact with his daughter. Three patients had separated from their families in the preceding year or two (076, 084, 203), and the relevance of illness to this behaviour is not ascertainable. One of these (203) had married shortly before admission but had never lived in this matrimonial home, and had very limited contact with his family by his previous first marriage. The other two had no family contact whatsoever. Six male patients lived within the nuclear family, five of the six continuing to act as the major income earner (034, 071, 105, 133, 137). The fifth patient

(285) remained off work, sick, until the study closed, but his post was kept open for him. One patient lost contact rapidly after discharge and his circumstances are not known (299). Two West Indian youths (163, 253) did not return to their cohabitees and children after discharge, but both retained frequent contact with their children and gave informal financial support to their partners. One patient (353) had returned to his parental home a few weeks before admission, but retained frequent contact with his infant son, and continued to live with his parents. Of the two other male patients, one murdered his wife (049), and hence his children remain with their maternal grandparents. Infrequent supervised access to the children is permitted for this patient who remains in hospital under Section 65 of the Mental Health Act. The last patient (110) had care of his 6 year old son for three years prior to his admission, but both paternal and maternal grandparents had substantially cared for the child, often for weeks or months at a time. During the follow up period the patient had engendered such social chaos that both sets of grandparents were making mutual efforts towards legal proceedings, fearing for the safety of the child.

Of the seventeen male patients therefore, child care has continued without substantial outside help in six cases where the patient had full participation, and unaltered with little or no patient participation in a further five . Patient participation in child care has been reduced or removed in five cases, and is unascertainable in one.

Female Patients with Offspring who are Minors

TABLE 7.8

Care Arrangements of 50 children of 36 female patients

	At Admission	At Close F/up
Living with single parent (patient)	14	11
Living with extended family	3	6
Living with nuclear family (both parents)	24	24
Child living with well parent (not patient)	1	0
Judicial or voluntary care	5	7
Status unknown		2
	47	50

Thirty-three female patients had produced forty-seven children previous to admission, and three patients bore children during the follow up period, two within marriage and one illegitimately.

Eighteen patients were married, ten were divorced or separated and eight patients had borne illegitimate children. Six of these eight patients were of West Indian background, a culture in which childbirth outwith marriage is not uncommon.

Two of the married patients (018, 336) had come to Britain from overseas, one in the company of her spouse who was entering postgraduate medical studies, and one entering postgraduate studies in her own right. Both patients had puerperal illnesses, and returned home. The latter patient is the only female who had left her child in the care of her partner at the time of admission. The patient who married and bore a child (075) during follow up became unwell in pregnancy, but remained supported by her many siblings. One married patient (348) failed to achieve discharge, and of the

remaining fourteen married mothers substantial assistance in child care was provided for six patients (seven children). One patient (040) had a full-time nanny, one patient (108) returned to her parental home for over a year and when a nursery placement was found for her child re-established her own home but later obtained a full-time au pair. Her spouse was very supportive throughout. Two patients remained in medical care for protracted periods and later spent time in mother and baby specialised units (047,345). During the hospitalisation of these two patients the children were cared for by grandparents and au pairs. One patient spends weekends with her mother, and during the week her mother in law lives with her (087); and one patient had her son removed to legal care by social services, but after one year a slow return to parental care is being organised (270). For all of these patients the arrangements have persisted for months. The eight patients managing within the nuclear family alone have older children (111, 155, 179, 221, 222, 368) (6 cases) and very supportive spouses (297, 522) (2 cases).

Of the ten divorced or separated women, two lived with their parents (168, 138) and one other decided to do so (121). One child of patient 151 remained in a hostel for disturbed adolescents under legal constraint. The patient (151) had an elder child who had left home some time previously (see footnote table 7·6)The child of one patient (259) was fostered during her mother's hospitalisation, but remained in care after the patient achieved discharge. Two patients continued to care for their children unaided (296, 374) after discharge. These children were of school age, and those of patient 296 came to informal care when the patient began a protracted second admission. One patient returned home to her three children (135)

who, in their early adolescence were obliged to organise her admission under the auspices of the Mental Health Act. One patient continued to attend day care until the study closed (379), and the tenth patient, although divorced, continued to cohabit intermittently with her spouse (342). Although she had care of her nine year old son, and continued in employment in a reduced capacity, much informal aid with child care from her family and from that of her spouse was utilised.

Eight patients had illegitimate children. One patient had her child removed to legal care many years ago, whilst living abroad (330), and another patient had her child in care for years prior to admission (352). The child of patient 161 remained in care from admission until the termination of follow up, two years later, when the patient remained in day care living in a hostel. The patient who produced an illegitimate child during follow up continued to live with her extended family (236) and to intermittently attend day care. Grandparents had played a substantial role in the care of one child (patient 011) and at two years, post discharge, were seeking full care of the child. Three patients live alone with their children. One patient (148) with two school aged children, has persistent positive symptoms and much insight and is aided by psychiatric nursing and social work support. The two other patients are more successful, one living (078) with her twelve year old son on social security as she has done in the past. The eighth patient is employed full-time, has achieved academic success in a limited style and cares unaided and with ease for her daughter (037).

At the close of follow up,of the 50 children under the age of 16 years born to thirty-six female patients, relatively few are

cared for by their mothers, without aid. Two children are abroad; their status is unknown. Seven children were in the care of social services at follow up and six children cared for by grandparents, who in two cases were seeking legal supervision of the children. 24 children remained in the setting of the nuclear family, but one mother remained hospitalised and five of these children were cared for by relatives or helpers. Eleven children remained in single parent homes, with substantial aid provided for three children, no additional aid for three, and one child attending school whilst his mother continued to attend day care.

Summary of Child Care

There was little evidence of alteration occurring in the arrangements as between adult offspring and patients, but increased support and periods of residence with the children occurred.

Of the eighty-five minors, details are insufficient in two; these are discounted. No male patient cared for his child successfully, unaided by a well spouse, and only seventeen children from nuclear families of male patients remained cared for in that setting, from an initial twenty-three. Twenty-four children remained in the nuclear families of their unwell mothers, but four patients with infant offspring required substantial support and one mother remained hospitalised. Children in one parent homes fared better if they were older, and involvement of grandparents increased and remained high throughout the follow up. Only one child under the age of five years, from a possible of eleven children, remained cared for by her unsupported mother. Nine children were in the care of social services for protracted periods, all for longer than one year.

These data were collected only two years or less after the index hospitalisation.

Discussion of Outcome

The outcome for this sample is comparable with the recent studies by Bland (1976) Nyman and Jonsson (1983). The examination of outcome is compounded by loss of contact within six months of 9.8% of the sample. Figures for those requiring very protracted admission (5.1%) may be reasonably combined with those who received community based support of an extensive kind, such as full day care or residence in supportive hostels (5.1%). This 10.2% of the sample may be considered as the worst outcome group in terms of return to the community and ability to resume function within society. It may perhaps be pessimistic to view these cases in such a fashion, but the distribution of these cases spans all hospitals and seems thus to supervene hospital policy.

The examination of employment must be viewed in relation to the availability of employment within 30 miles of north west London, during the years between 1979 and 1982. The difficulty in establishing a clear catchment area confounds analysis of these features in any realistic terms but unemployment rose from 1979 to 1982, and affected the young and the racial minorities, both features of this population. In such a setting return to employment at discharge might be expected as a feature associated with good prognosis as discussed in Chapter V and VI.

Students fare relatively poorly, echoing Nyman's finding (Nyman and Jonsson, 1983) that only 3 of his students were successful in academic achievements. Marriage was infrequent and the ability of this sample, in the short term to care for minors unaided was

impaired.

The author perused the case notes and outcome variables of the sample in an attempt to define that population which Nyman referred to in his sample as having the very best outcome. The variable length of follow-up proved a difficulty, and hence the author selected these cases who had remained in contact until the study closed or until the elapse of two years. Discounting those who relapsed or came to readmission this yielded 56 cases, of whom 41 were participants in the prophylactic drug trial, and 16 were receiving standard care. (50 other cases recorded as well but loss of contact occurred before two years or close of the study, and they were discounted). The requirement to be classed as the very best outcome was that an achievement, academic occupation or social, be made, no matter how limited. The author found 10 cases of definite achievement and 3 where they might be probable achievement. The details of these cases are displayed.

TABLE 7.9

Achievers' Table

Case No	Age	Sex	Duration onset to discharge (months)	Discharge to employment yes/no	Treatment after discharge A/P/S	Duration drug treatment (months)	Length of follow-up
Definites							
004	39	M	4	yes	A	11	24
007	21	M	6.5	student	P	4.5	24
019	21	M	2	yes	P	3.5	24
037	22	F	4	yes	P	3.5	24
061	25	F	5	yes	P	3.5	24
085	28	F	3	yes	P	4	24
102	37	M	1	yes	P	4	24
186	30	M	9	yes	A	22	20
190	17	M	4	yes	P	3	20
107	26	M	36	no	S	27.5	24
Probables							
114	18	M	11	no	P	11	18
163	25	M	11	no	P	75	19
027	22	M	11	student	S	17	24

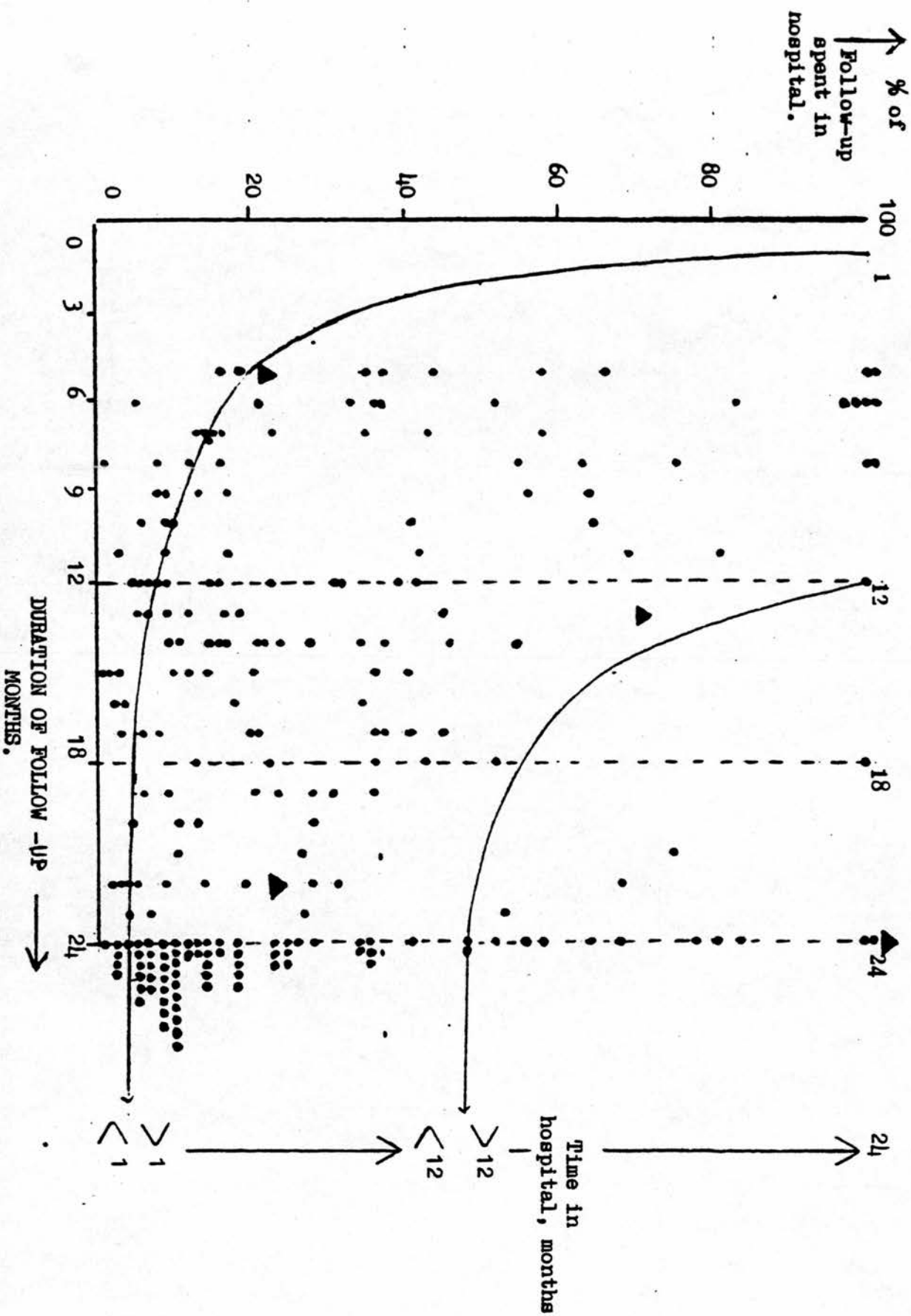
The achievements of these cases are fully described in the Appendix, but include completion of studies (3 cases) and restarting postgraduate studies (1), forming lasting heterosexual relationships or marriage (5 cases and 1 doubtful case), and achievement in employment (6 cases and 2 doubtfuls). These occupational achievements ranged from the acquisition of a full time lecturer post

in a polytechnic and promotion within an orchestra, within the motor manufacturing industry, to the modest achievement of a place on a retraining scheme by a limited youth (No 114). The striking feature of these cases is the paucity of medication, nine cases being allocated to placebo maintenance. The patient with a very protracted period of illness prior to admission was maintained on depot neuroleptics throughout follow-up, and there is no doubt as to his diagnosis. The author would suggest that cases 007 and 085, both with family histories of affective illness fall into the group described by Valliant (1963) as having a good prognosis related to their manic depressive heredity.

Thus 5.1% of the total sample are known to have made achievements if doubtful cases are included, and the role of neuroleptic long term treatment in these cases is restricted to the minority.

The study would support the view that the outlook for schizophrenic patients presenting for the first time is not universally poor, but that even at this very early stage of the illness the overwhelming majority are not likely to regain the ability to achieve within two years. For most patients the diagnosis of schizophrenia is linked with an outcome characterised by high relapse, readmission and impaired function. It may be reasonable to make this diagnosis at a first illness and to entertain the possibility of prolonged medication. However for the individual case, as so clearly demonstrated by patient 107, a disturbed patient with a protracted delay in admission, prediction of a poor outcome may be erroneous. The possibility of drug responsivity combined with good premorbid function may override all

prognostication.


% of Follow-up spent in hospital.
0
20
40
60
80
100
1
12
18
24
0
3
6
9
12
18
24
DURATION OF FOLLOW -UP
MONTHS.
● patients
▲ dead
< 1
> 1
< 12
> 12
Time in hospital, months
24

Graph 7.1

CHAPTER VIII

Judicial Involvement and Death

The assessments included enquiry of patients and relatives as to judicial contact. At follow up direct contact and examination of the case notes supplemented this initial data. Interpretation of behaviour within the months preceding admission as psychotically based or not was performed by the interviewer using the account by the patient and other informants, determination of the date of onset, and examining the nature of the behaviour.

A total of 71 cases had some legal contact which was made known to the author. The table demonstrates the relationship between past offences, contacts at admission and judicial contacts during follow up.

Judicial Contacts for Total Sample

Past Record		At Admission	Close of Follow-up
Criminal offences	30	18 with contact	2 with contact/16 none
		12 none	1 with contact/11 none
No criminal offences	223	37 with contact	4 with contact/33 none
		186 none	4 with contact/182* none
Total	253	253	253

182* No judicial contact during study.

This chapter is largely descriptive and details three aspects of judicial contact:-

1) Past offenders

The 30 cases with a history of criminal offences are described, and the 12 cases who had no additional contact at or around admission are reviewed in detail.

2) Contacts at or around admission

The 55 cases who had contact at or around admission, including the 18 cases with past criminal records are described, with references to the responses of relatives to these contacts. The difficulties in making a clear distinction between recalcitrant behaviour and that due to illness alone is mentioned.

3) Contact during follow up and deaths

The contacts and deaths are described for this small number of cases.

1) Past offenders

Of the 30 patients with past charges occurring within five years preceding the admission date, 8 had four or more offences and 22 had three or less. Additional contact clearly due to illness at or around admission occurred in 18 cases, of whom 5 had past records of four or more offences, and 13 had 3 or fewer offences. 12 patients with past criminal records had no new judicial contact leading to hospital contact at or around admission.

Past Offenders	1-3 offences	4 or more	total
All patients	22	8	30
With additional contact	13	5	18
No additional contact	9	3	12

The difficulty in making a clear distinction between behaviour associated with illness and other behaviour is well demonstrated in this latter group of 12 patients. None of these patients were referred to psychiatric care from judicial services.

12 patients/offences occurring within 5 years of Index Admission/No new contacts leading to hospitalisation

Pt No	Age	Sex	Race	Nature of Judicial Contact
001	28	M	C	Immigration dispute
002	30	M	N	Borstal training. Theft. Domestic violence. Customs & Excise offence.
008	31	M	C	Theft. Aquitted.
052	25	M	C	Disturbance of the peace.
068	21	M	M	Disturbance of the peace
104	22	M	C	Theft
195	20	M	C	Theft
208	22	M	C	Borstal training. Multiple offences of theft.
217	33	M	C	Failure to pay maintenance.
262	21	M	C	Assault.
321	22	M	C	Drunkenness.
330	32	F	C	Repeated deportation. Dispute concerning legal care of child.

Patient 001 joined his brother in Britain and was employed in a capacity compatible with his previous clerical employment in Greece. He had planned to remain in Britain on the assumption that his native land would enter the European Economic Community. The delay in this event led to protracted immigration disputes. The interpretation that the patient left his home in the early stage of his illness is not supported by the account of the acute onset of his illness, described by both patient and relative.

Patient 217 had been known to display episodes of bizarre behaviour for many years, noted by his sister with concern. However, she described his failure to pay maintenance as entirely acceptable behaviour unrelated to illness.

Patient 330 described her paranoid delusions well, and said she had held this belief with full conviction for eight years. However she consistently denied any psychiatric contact during the protracted and continuing legal dispute concerning the deprivation of maternal rights she had experienced, nor any psychiatric contact during her repeated deportations from Europe. Despite the view of the patient, and the failure to obtain another witness, it remains possible that this behaviour was related to her paranoid psychosis.

2) Contacts at or around admission

55 patients had contact with the police or other judicial services at or around admission of whom 18 had records of criminal offences in the preceding five years. The nature of the contact, and the extent of past offences are tabulated and described.

Judicial contact occurring between date of onset and date of admission

Nature of judicial contact	No past offences	1-3 offences	4+ offences	Total
a) Section 60 MHA	8	2	2	12
b) Section 136 MHA	11	0	0	11
Taken to hospital by police at contact	8	6	0	14
c) Other contact with charges	6	2	3	11
Other contact without charges	4	3	0	7
Totals	37	13	5	55

a) Section 60 of the Mental Health Act

Twelve patients were transferred to hospital under the auspices of Section 60 of the Mental Health Act. Eleven patients were males, of whom six were caucasian and five negroid. The nature of the behaviour leading to detention and the past records of judicial contact are detailed below.

Section 60 Patients

Pt No	Age	Sex	Race	Behaviour	Past Offences
027	22	M	C	Theft from parental home	Possession of cannabis
041	22	M	C	Attacked warders repeatedly in prison (theft)	Recidivist
044	25	M	C	Shoplifting	Shoplifting. Possession of cannabis
095	56	F	C	Debt	None
128	21	M	N	Assault	Recidivist
144	22	M	C	Criminal damage x 2	None
200	22	M	C	Criminal damage	None
207	28	M	C	Arson	None
280	22	M	N	Theft	None
335	22	M	N	Theft and arson	Unknown
371	23	M	N	Unknown	Unknown
372	22	M	C	Assault	None

The mother of patient 027 contacted the police to press charges in the hope that this would result in psychiatric intervention. Patient 041 had been in the care of social services as a child, and moved from borstal training to repeated prison sentences. At the

age of 22 he had never spent longer than nine months outwith institutional care, and had a long history of gratuitous violence. Patient 044, although only 25 years old, was of no fixed abode, and was obviously hallucinated when detained for ill organised shoplifting. He had received private education as a child and already served one prison sentence in the past. The only female patient detained under Section 60 had for psychotic reasons refused to pay all domestic bills and rates for two years, in the belief that local authorities and television personalities were in league together. Patient 128 was very well known to prison and probation services, and was on probation at the time of his assault upon a stranger. His brother is detained in a special hospital at the time of writing. With one charge of criminal damage pending, a second similar offence led patient 144 to prison detention and psychiatric referral. The criminal damage resulted from sudden violence at home and in the local area.

Patient 208 threw a brick through a window, believing this would persuade his supposed persecutors that he had no connection with the Irish Republican Army. On bail, he absconded to Eire, but when he appeared in court and described his beliefs psychiatric referral occurred. Patient 207 whilst attempting to set fire to himself, set fire to a house and was charged with arson. Arson and theft were the offences leading to the detention of patient 335, who had recently travelled to America under the influence of psychotic beliefs. The theft of a car was prompted by the desire to evade supposed persecutors for patient 280, and patient 372 brutually attacked his father in the belief that he was the devil incarnate. His father took his discharge from the hospital within hours of the

attack, and sought legal advice to ensure his son should reach immediate psychiatric care.

Relatives were available for interview by the investigators in five cases. In three cases unsuccessful attempts to gain psychiatric aid had preceded the described events, and in all cases medical aid was hoped for subsequent to police intervention.

b) Section 136 of the Mental Health Act and Informal Admission

Twenty-five patients were brought to hospital directly by the police, in eleven cases Section 136 of the Mental Health Act being instituted empowering the judiciary to take the patient to a place of safety and in 14 cases informal hospital contact was made by the police.

Section 136 (11 Cases)

Pt No	Age	Sex	Race	Nature of Contact
018	27	F	N	Ran out of house. Locked in a van. Neighbours contacted police.
030	27	M	N	Disturbed behaviour in public place.
082	26	F	N	Disturbed behaviour in a public place.
178	20	M	C	Found wandering aimlessly.
227	17	M	N	Disturbed behaviour in public place.
254	21	M	C	Ran out of house through plate glass door. Jumped into a pond.
289	17	M	N	Domestic violence.
336	24	F	A	Disturbed behaviour in a large shop.
359	26	M	N	Assaulted eight female strangers within a few hours.
522	28	F	N	Ran off from home, screaming.
589	40	F	O	Domestic disruption for months. Neighbours contacted police.

None of these patients had past judicial contact.

Brought to hospital by police informally (14 Cases)

Pt No	Age	Sex	Race	Nature of Contact	Past Judicial Contact
003	28	M	C	Found wandering some miles from home town.	Arson - probation Possession of offensive weapon - fined.
017	20	M	C	Found wandering on a railway line	None
022	39	M	C	Spoke of hanging himself over stair well of lodgings. Police called by landlady.	Failure to pay maintenance
028	20	M	C	Found in respiratory distress having cut his throat	Arrested in student political demonstration
033	21	M	N	Domestic disturbance, police called.	None
049	24	M	N	Domestic disturbance with violence. Neighbours contacted police.	None
083	24	M	M	Family contacted police after repeated domestic violence.	Deportation. Disturbance of the peace.
084	26	M	C	Attempted to climb boundary wall of Royal Residence.	Failure to pay maintenance
107	26	M	C	Removed from roof of parental home, clad in ladies underwear only	None
145	19	M	N	Fought with police dog when challenged for bizarre behaviour in public park	None

Pt No	Age	Sex	Race	Nature of Contact	Past Judicial Contact
149	25	M	A	Apprehended by motorway police, having driven up motorway on wrong side, and attempted to lift car over a gate.	None
313	39	M	C	Patient asked friend to telephone police for protection from supposed persecutors. Armed police arrived.	Drunken driving (under an assumed name)
317	21	F	N	Patient ran away after sudden domestic violence. Family contacted police.	None
340	24	M	A	Found wandering in a public place by police.	None

Nineteen of this group of 25 patients were male and six were female. Seventeen patients were of negro, asian or oriental racial origin as opposed to eight of caucasian race. Domestic disturbance, aimless wandering and disturbance in a public place precipitated police contact which resulted in both informal admission and implementation of Section 136. Behaviour involving violence directed towards the self and towards others occurred in two cases detained under Section 136 and in three cases taken informally to hospital. The use of Section 136 may bear some relation to the ease of communication between the individual and the judiciary, which may have been hampered by limited command of English or heavy accents as in cases 018, 082, 589, 522 and

extremely limited spontaneous speech in cases 336, 254 and 178. However the patients brought to hospital informally were not universally compliant, cases 107, 022, 313,049, 083, 149, 084, 033 and 003 all being detained during their index admission under various sections of the Mental Health Act. Patient 028 required intensive care, a tracheostomy and later was detained formally after several suicidal attempts.

Only in the case of patient 145 was it unclear to the police that psychiatric referral was appropriate. Patient 145 was found jumping, shouting and dancing in a public park waving two sticks. When challenged to desist the patient fought a police dog, and was brought to a casualty department for attention to severe lacerations of his left leg. The casualty officer sought a psychiatric opinion, resulting in immediate admission.

c) Other contact with and without charges

Eighteen other patients had other forms of contact with the police, resulting in charges being pressed in eleven cases. Hospital contact made by legal services on behalf of the patient was the late result of such an event in one case.

Other judicial contact with charges (11 Cases)

Pt No	Age	Sex	Race	Nature of Behaviour or Charges	Past Offences
012	22	M	C	On probation and awaiting trial for theft.	Theft burglary forgery deceptic
073	27	M	C	Dangerous driving, case pending on admission.	None
081	35	M	C	Shoplifting. Charge pending on admission.	Shoplifting x 3
131	19	M	C	Place in remand centre. Offences unclear. Psychiatric attention whilst on bail.	Drug charges Theft
180	21	M	C	Forced girl into a car to drive him many miles. Charged, convicted, fined.	None
193	20	M	C	Making menacing phone calls to previous employers, charged and convicted. Continuing to sue employers for wrongful dismissal at admission.	None
203	46	M	C	Breaking and entering. Placed on probation and later referred for psychiatric opinion.	Failure to pay maintenance
220	21	M	C	Broke into cars. Charged, convicted, fined.	Possession of Cannabis

224	17	M	N	Found wandering. Broke policeman's finger in fight. Charged resisting arrest.	None
246	50	M	C	Assault of neighbour. Charged and fined.	None
299	22	M	N	Theft of camera. Court case pending on admission.	None

Other contact without charges (7 cases)

112	19	M	N	Ran off from home. Police found him in Salvation Hostel and contacted family.	Fined for stealing a car.
146	29	M	C	Police found him when family reported him missing, and contacted family.	Road Traffic offence
202	21	M	C	Detained overnight in police cell for driving bicycle without lights. Not charged, returned home.	None
218	43	M	C	Repeatedly over years returned home by police found wandering or creating disturbance in the street.	None
241	34	M	C	Police removed patient from local hotel, which he had refused to leave	Loss of driving licence.
253	23	M	N	Picked upon suspicion but released.	None
293	20	F	C	Detained by police on suspicion of soliciting. Taken to parental home.	None

For this group of patients their contact with the police did not lead directly to hospitalisation, either formally by the use of Section 136 or 60, or informally by immediate hospital contact. This distinction is arbitrary, as the use of Section 60 was in some cases instigated by relatives and for patient 145 the direct hospital contact was initially based upon physical injury, although psychiatric admission was the result.

The cases who were charged with offences

Patient 224 described how the police found him, somewhat dishevelled and barefoot, in the middle of a road miles from his home town. He resisted their attentions with considerable violence, breaking a policeman's finger, and was detained in the police cells. His mother realised he was unwell when she saw him there, but was uncertain as to how to proceed. The mutual decision between police and relative was that the patient return home after being charged, which was effected by public transport. The patient greatly alarmed his mother by walking backwards down the railway platform, giggling and grimacing, apparently unaware of his surroundings. Hospitalisation occurred a few days later. Charges were pressed but dropped after eight months, whilst the patient remained in full time day care and was continuously auditorily hallucinated.

The family of patient 012 described him as always difficult, he had attended borstal training and had a long record of charges. The onset of illness was difficult to determine, but the patient had expressed the idea that his family stole things from him and he had

begun to smash articles in the house, occasionally displaying sudden inappropriate tearfulness three years prior to admission. Eighteen months prior to admission he was arrested for burglary and complained of hearing his victim threatening him in the police cells, whilst the patient was alone. He refused to sleep in his own room and slept on the floor of his parents' bedroom. When he complained of a spider in his chest affecting him, medical contact was made resulting in immediate admission.

The parents of patient 073 had been advised to seek psychiatric help for their son some eighteen months previously. At this time the patient was attending a retraining course, and was asked to leave. The staff made efforts personally and by letter to encourage psychiatric contact. A year later he was charged with dangerous driving. Hospital admission followed six months after this charge, when the patient was extremely destructive at home, in his parents' absence. The diagnosis was made with difficulty due to the reluctance of the patient to fully discuss his undoubted delusions.

Patient 180 had been wandering from home at night during the period of one year prior to admission. The household consisted of an invalid father, and a shifting population of three to five adolescent children. The reported incident ocurred nine months prior to admission. The court case occurred many miles from home and the anxiety for the patient's safe return precluded any effort at psychiatric aid, although recognition of this uncharacteristic behaviour as being due to illness did not clearly occur to the family at this time.

In case 131 and 220, relatives expressed disappointment that police intervention had not led to psychiatric contact, which had been sought unsuccessfully through other channels by relatives prior to the offences. These relatives attempted to encourage psychiatric referral by the judiciary but were uncertain as to whether or not they had proceeded through the correct channels. (Neither had sought legal advice, in contrast to the relatives of patients 027 and 372, where Section 60 was implemented.)

Patient 246 came to admission a year after assaulting his neighbour, but had held delusional beliefs concerning vice rings for seven years. His behaviour was clearly attributed to those ideas by both the patient and his sister, who had been unable to convince her brother that he needed psychiatric help.

Patient 193 had behaved violently at work, which led to his dismissal. The patient did not necessarily attribute his behaviour to any special set of beliefs and his mother attributed his illness to the stress of the court case. The relationship between his behaviour and his illness remains unclear, as is the case for patient 081. This youth had suffered severe social decline, having gained university entrance some years previously but never completing the course. On admission he was of no fixed abode, and his charge was pending. He appeared in court after he was discharged to a hostel and was fined only, on the basis of psychiatric reports. No relative was available to expand upon the details of the judicial contact for case 081, nor for patients 299 and 203. Information as to the behaviour and mental state of patient 299 at the time of the theft of a camera is so scant as to preclude any interpretation. An experienced probation officer dealt with

patient 203, who committed his offence many miles from home. The circumstances were bizarre. The patient entered a building from the fire escape to no obvious purpose, and was found sleeping in an office. He could not account for his behaviour, and over the following months expressed vague ideas of guilt for personal offence he may or may not have caused others in casual conversation. Referral for psychiatric opinion resulted in admission for observation, which eventually revealed delusions occurring in an apophanous mood state (Fish, 1976). Contact with others who had known him in the past confirmed the alteration in his mental state and it could be postulated that the offence may have borne some relation to the illness this man suffered.

The cases with contact but no charges

Seven patients had contact with the police leading neither to changes nor hospital contact. In two cases, patients 112 and 146, the family sought police aid to locate their unwell relative. One young female patient, 293, was initially thought to be soliciting, but was returned to her parental home. Patient 218 had been well known in the local neighbourhood as prone to episodes of some months duration where he would shout and sing in the street, or wander off and sleep in the open country for a few weeks. The local judiciary always brought him home. A television programme proffered the explanation of psychiatric illness to his elderly parents, and they took steps to seek aid thereafter.

The relationship between the behaviour of patients 241, 202 and 253 and their illnesses is difficult to determine. Patient 253 was

wandering from home, within a few weeks preceding admission, and his contact with the police during that period was fleeting. The degree of evident disturbance of his mental state is not ascertainable. Patient 241 was refusing to leave the hotel as the basis of his psychotic experiences (he was receiving commands from a computer in the sky) but he was not entirely alcohol free on this occasion. His parents organised admission through the family doctor after an unsuccessful attempt to take him to the hospital directly. After being detained overnight patient 202 was taken or sent home. He was hallucinated at that time, but had not informed the police of this. His mother, a chronic schizophrenic, was unable to deal with the situation, and mother and son travelled 100 miles by taxi to seek aid from the patient's married sister.

Judicial contact during follow up and deaths

Patients who died

Pt No	Age	Sex	Race	Time from index admission	Nature of death	Coroner's verdict
No past record						
020	18	F	C	12 months	Overdose while on w/e leave	Suicide whilst balance of mind disturbed
132	36	M	C	22 months	Overdose and suffocation	Suicide whilst balance of mind disturbed
Past record and contact at/around admission						
022	39	M	C	15 months	Drowned in bath	Death by misadventure
131	19	M	C	13 months	Overdose on leave	Death by misadventure

During the period of follow up four patients died and seven patients had further judicial contact that was made known to the investigator.

Patient 020 had not achieved discharge after two years continuous hospitalisation. Her illness responded poorly to high doses of neuroleptics. Her mother gave a history of the patient having been housebound for eighteen months prior to hospitalisation, after she had left her job on the basis of paranoid ideas.

The elderly parents of patient 132 described a decade of bizarre and aggressive behaviour; the patient preoccupied with writing screeds of incomprehensible notes. On admission the patient expressed his wish to castrate himself in the belief that the devil had entered his sexual organs. He improved and was maintained in day care but his second admission was precipitated by his complaint of incapacitating akathisia. After discharge he expressed despondency at his situation and then organised a well planned suicide, sending a letter to inform his family as to where to recover his body.

A history of drug abuse initially confounded the diagnosis of patient 131, but his illness ran a steady downhill course, leading to repeated detention under various sections of the Mental Health Act. This youth had been in a remand centre prior to the index

admission. On weekend leave during the course of his third admission, the patient died from an overdose of diconal.

Patient 022 worked as a gardener with his brother, and lived with a supportive landlady. His past criminal record included failure to pay maintenance and two minor thefts, much in keeping with his cultural background. Admission was effected with the aid of the police when he spoke of hanging himself. He refused medication within six weeks of discharge after brief hospitalisation. Five months after the index admission he drowned in the bath of his brother's home. The brother described no change in the patient, but noted the quite uncharacteristic action of taking a bath, especially in the early afternoon, and the unusual finding of clothes lying neatly folded outside the bathroom door.

Seven other patients are known to have had new judicial contact after the index admission date. Patient 076 was deported three months after discharge from hospital. He had lost contact with the investigators one month prior to this event, but the police made an enquiry of the base hospital at the time of deportation. Further details are not available. Similarly the information concerning patient 359 was derived from an incidental police enquiry seeking the patient's nearest relative, in order to make contact and charge the patient with theft. The nature of these contacts might suggest that judicial contact after discharge is likely to have occurred without the knowledge of the investigator, and this is certainly possible where contact was lost early in the follow up. Patient 088, who was charged, convicted and fined for indecent exposure a year past discharge, had no known other judicial contact.

New judicial contact in follow up

Pt No	Age	Sex	Race	Charge	No Past Record No admission judicial contact	
076		M	C	Deported	None	
088		M	C	Indecent exposure	None	
					At Admission	Past Record
289		M	N	Malicious damage	Section 136	None
262		M	C	Actual bodily harm	None	Assault
280		M	N	Prison requesting Section 60 Charge not known	Section 60	None
049		M	N	Murder	Brought by police	None
359		M	N	Theft	Brought by police	None

Patient 289 had held employment as a trainee painter and decorator. He was admitted under Section 136 of the Mental Health Act and was later charged with malicious damage, but entered hospital care from police custody. Unpredictable violence proved a management problem in hospital. Eleven months after the index admission the patient has nuclear features of schizophrenia and

remains in his second hospital admission.

Patient 262 had a past offence of assault apparently hitting out, unprovoked, at a negro neighbour. Contact was refused by the patient two months after discharge. Eighteen months post discharge the patient made a request for psychiatric aid, explaining that he had been charged with actual bodily harm. The relevance of illness to this later behaviour is not known to the investigator.

Patient 280, the son of a known schizophrenic, was hospitalised under Section 60 of the Mental Health Act, after the theft of a car. A two month admission was followed by rehospitalisation four months later, for only six days. He was then referred for a psychiatric opinion via the prison services, with a request for placement under Section 60 once more.

The seventh patient with known judicial involvement after the index admission was a young negro male (049). He was married to a divorcee, and was stepfather to one child and the natural father of the other. His wife had been admitted in a disturbed state under Section 136 on at least two occasions in the past, but had never remained in hospital for more than a few days. His own admission was effected by the police, following domestic violence, without the use of Section 136. The patient undoubtedly held delusions that his spouse and her family were affecting him by witchcraft, but he responded to oral medication and gained insight. The patient returned to work, eight weeks after his five week index admission. Seven months later the patient killed his wife by repeated stabbings with a kitchen knife, while the two children slept upstairs. Within hours he went to the local police station to describe the events of the night. Psychiatric attendance occurred

while the patient remained in prison for six months. Then he was transferred to his base hospital under Section 65 of the Mental Health Act. At two years post the index admission patient 049 remains detained at the pleasure of the Secretary of State, and has had very limited supervised visits to his two children. His mental state now reveals no abnormality, and he has full recall of and insight into these events.

Summary and outcome

A total of sixty patients had judicial contact during the period of their first schizophrenic illness or during follow up. A further eleven cases had records of past offences but no known contact during the period of study. Although in 182 cases there is no record of past offences or contacts, it may be that patients and relatives concealed past offences, and it is probable that the author is ignorant of other relevant information.

The nature of the behaviour was sometimes severe or dangerous, and death occurred in four cases and homicide in another case.

The relationship between criminality and schizophrenia has been explored in the forensic literature, but conclusions are conflicting. In this study the lack of systematic collection, especially of judicial contact in the follow up, leaves the information as largely anecdotal. The extent of contact, with 55 in judicial contact from a total of 253 cases, is impressive.

Despite the judicial contact sixteen cases had favourable outcomes, achieving discharge and not experiencing a noted relapse or readmission.

d) The outcome for the 71 cases is very briefly described

Cases derived from total sample

Total 1st Episodes of Schizophrenia 253

1) Past Criminal record 30

No past criminal record 223

2) Contact at admission 37

No contact at admission 186

3) Late judicial contact 4

No late judicial contact 182

Total with record or contact 71

The short term outcome for the 253 cases has been described. The outcome for this special group is tabulated.

		Lost Contact	Not discharged Continuing Care	Relapse Readmission	Death or Charges	None of these
1) Past criminal record	30	4	3	11	3	9
2) Contact at admission	37	7	7	12	4	7
3) Late contact only	4				4	
		11	10	23	11	16

The 55 cases who had judicial contact at or around admission may be compared with the 198 cases where there is no record of such contact. There is a marked predominance of males, 48 of the judicial contact group being male, and only 7 being female. This may account for the younger age of the judicial contact group, mean 25.7 (standard deviation 8.2) compared with the mean age of the total population of 27.0 yrs (standard deviation 7.6). The 55 cases did not differ from the rest of the sample in terms of mother tongue, nor in terms of race.

More lived with parents than with others or alone, at a statistically significant level ($chi^2 = 8.01$, 2 df, $p<0.05$). There was a non-significant trend for those having judicial contact to have been ill for longer than one year more often, but this may be interpreted with extreme caution as, in excess of this group, the duration of illness was not established. These details are tabulated below, along with comparisons based upon the measures of disturbed behaviour preceding admission. The population with judicial contact were rated as having higher scores on the disturbed behaviour scale, at a statistically significant level (t test two tailed 3.192, $p<0.002$). Fifty ratings of disturbed behaviour are available for the 55 judicial contact cases, and 172 ratings for the 198 cases without such contact.

Examining each of the five noted behaviours demonstrated differences between the groups, with the judicial contact group more often exhibiting behaviour threatening to the life of others, damaging to property, and bizarre behaviour. There was no significant differences between the groups in terms of behaviour threatening to the life of the patient or disturbed sexual behaviour.

55 Cases Contact at or around Admission

No.			55	198	$chi^2 = 23.8$
Sex	M		48	100	1 df
	F		7	98	$p < 0.000$
Age		mean	25.7	27.04	
		st.dev.	8.18	7.6 (253 cases)	
Race	Caucasian		32	134	
	Other		23	64	NS
Mother tongue:					
	English		44	161	
	Other		11	37	NS
Living with:	Alone		17	87	$chi^2 = 8.01$
	Parents		27	57	2 df
	Other		11	54	$p < 0.05$
Onset to admission:					
	1 yr		25	132	$chi^2 = 3.85$
	1 yr		18	48	1 df
	NK		12	18	$p < 0.05$
Disturbed Behaviour					
Total score	No.		50	172	T = 3.192
	mean		4.3	2.9	$p < 0.002$
	s.d.		2.85	2.8	
Positive score for each					
behaviour:	1		21	53	NS
	2		17	31	$chi^2 = 5.81$, 1 df $p < 0.05$
	3		8	29	NS
	4		18	28	$chi^2 = 9.17$, 1 df $p < 0.01$
	5		42	111	$chi^2 = 6.85$, 1 df $p < 0.01$

CHAPTER IX

The Home Environment

Literature Review

Since the early 1950s the proportion of schizophrenic patients achieving discharge to the community from hospitalisation has risen, and the home environment, long considered a factor in the adjustment of schizophrenia, has been increasingly investigated.

Brown (1958) described a retrospective study of discharged male schizophrenics and noted the association between deterioration and the nature of the living group the patient returned to, patients faring better with siblings or in lodgings as opposed to with parents, spouse or in a large hostel. Suggestions that very limited social support could be as unhelpful as highly emotional atmospheres stimulated the formulation of standardised reliable assessments of the emotional aspects of the home environment. Rutter and Brown (1966) devised a semistructured interview which is tape-recorded with the relative who usually spends most time with the patient. This Camberwell Family Interview is later rated, and using defined criteria, the number of critical or overinvolved comments about the patient are counted. The central feature of the assessment is the number of critical comments, although overinvolvement may also be used to designate a relative as of High Expressed Emotion. A schedule concerning activities of daily living gives an account of the hours of face to face contact between the key relative and the patient.

An association between early relapse of schizophrenia and home environments characterised by High Expressed Emotion has been demonstrated by Vaughn, Leff and Brown using a mixture of prospective and retrospective studies. The nature of the association between High Expressed Emotion and early relapse has been further examined in relation to the behaviour of the patient and the use of prophylactic drugs.

Ratings of the mental state at discharge and assessments of the social behaviour of the patient in the two weeks preceding discharge did not account for the finding that high Expressed Emotion in the relative is associated with early relapse of the patient. These patients from High Expressed Emotion homes, however, showed more behavioural disturbance at the time of relapse than their counterparts, from Low Expressed Emotion homes (Brown, Monck et al 1962). Follow up for two years post discharge (Leff and Vaughn 1981) showed the differing relapse rates in the High and Low Expressed Emotion group, persisting over time, and that the benefit of prophylactic drugs in lowering relapse was applicable to all patients, not just those from high EE homes.

Examination of the nature and direction of a causal link between Expressed Emotion and relapse was the impetus for a trial of social intervention with the families of 24 schizophrenic patients, selected on the basis of Expressed Emotion being high, by Leff (1982). It remains possible that the reduction of face to face social contact which Leff achieved in some of these cases may be the result of improvement in the patient, rather than the cause of improvement. Falloon (1982) has cautiously expressed the view that contact with families at home may have been linked to increased drug

compliance, in his study of home based as opposed to hospital based contact and supervision of remitted schizophrenics. Leff has postulated that High Expressed Emotion is causative of relapse and has enquired as to the possible effects of Expressed Emotion at the first manifestation of the illness (Leff 1980). Although no relationship between duration of illness and Expressed Emotion has been demonstrated, it could be that the expectation of outcome, based on past experience, may affect the home environment. Thus where a patient is thought to be at risk of early relapse, on the basis of the past, or where relapse has been traumatic in the past, high Expressed Emotion in the relative could be induced or exacerbated. A mediating factor such as poor drug compliance might increase both criticism and relapse. Further, it may be that resignation to repetition of past events could lower social contact, or even Expressed Emotion, just as increasing anxiety as to outcome, based on past outcome, might increase social contact between relative and patient.

The Present Study

In this complex field of interactions the study of patients in their first episode of schizophrenia provided an opportunity to examine the home environment where relatives and patients had no experience of readmission or relapse. Measures derived from the Camberwell Family Interview such as critical comments and overinvolvement could be related to the severity of the behaviour at this, the first presentation of the illness. The sample was drawn from many centres and it was feasible to assess Expressed Emotion in differing social backgrounds, and in a youthful population who were often living with parents. (Overinvolvement is a relatively

uncommon feature of high Expressed Emotion, and has been found most commonly in spouses and parents.) The study of 1st schizophrenic episode patients was designed to examine the effect of prophylactic neuroleptic drugs against the first relapse. Hence it was possible to assess Expressed Emotion and social contact and relate these prospectively to relapse, taking prophylactic neuroleptics and placebo maintenance into account. Whilst all research inevitably involves a degree of selection, it would be further feasible to examine Expressed Emotion and social contact in a group of patients who did not participate in the neuroleptic versus placebo drug trial, to account for bias introduced by concentrating on only more co-operative or well participants. Finally relapse and readmission could remain blind to these other assessments, relapse and readmission being established by the clinicians with responsibility for the patient.

Materials and Methods

The principal assessment was the Camberwell Family Interview, (Rutter and Brown 1966) which included a budget schedule to assess hours of face to face contact with the relative. Assessment of the disturbed behaviour of the patient preceding admission was performed independently of the Camberwell Family Interview.

The Camberwell Family Interview

This interview is applicable where the patient has lived with others for three months or longer preceding admission. Patients from unassimilated immigrant backgrounds were excluded, but first and second generation immigrants and patients of any 'racial' origin were considered as potential candidates. The research psychiatrist assessing the cases sought consent that another research worker

could approach the family. The research worker, Mrs Aviva Gold dealing with this part of the study made her own contact with the family explaining that she wished to tape-record an interview with the relative who usually spent most time with the patient. The interviews were conducted within three weeks of admission. AG rated the tape-recorded Camberwell Family Interview she had made. Miss L. Kuipers from the MRC Social Psychiatry Unit trained AG in this method, and later blindly rated 12 random tapes from the series. The interrater reliability was high (Table I at close of chapter). The research psychiatrists remained blind to these assessments, and AG remained similarly blind to the clinical ratings and information obtained by the research psychiatrists. The collaborating clinicians remained blind to all assessments, bar the criteria for entry into the prophylactic drug trial following discharge.

A rating of behaviour was devised by J.F. Macmillan and E.C. Johnstone in response to the information concerning behaviour that was proffered by relatives during interview to collect socio-demographic data. Where no relative was available the research psychiatrists used information from the patient and case notes and other informants (probation officers etc). Five items were assessed:

i) Behaviour potentially threatening to the life of the patient

ii) Behaviour potentially threatening to the life of others

iii) Disturbed or inappropriate sexual behaviour

iv) Behaviour damaging to property

v) Bizarre inappropriate behaviour not classified above.

Each item was rated on a four point scale, as absent (0)

present once (1) present more than once (2), or present repeatedly for longer than one month(3). This original form of the disturbed behaviour rating thus included an element of severity and an element of duration (longer than one month), with a possible score ranging from 0 to 15.

Later a second rating was derived from this scale, for reasons described in the results. In this revised version each of the five items was coded as either absent or present. The intention was to remove any element of the passage of time, but of necessity precluded any assessment of the severity of the behaviour. Both versions of the disturbed behaviour assessments are referred to in the results.

Follow up

The follow up of the 120 trial participants and the 133 non participants and the definitions of relapse/readmission are described in Chapters V and VI. Of the 133 patients who did not participate in the prophylactic drug trial 116 were discharged by the entry date for the drug trial aspect of the study (2 Feb 82). Four of the 17 patients who did not achieve discharge by 2 Feb 82 did so within the next six weeks, and to preserve numbers their outcome is included. One of these four late discharge cases had an Expressed Emotion rating from a Camberwell Family Interview. Follow up of all these 133 cases was conducted at the close of the study and consisted of noting readmission, as the best available parallel to relapse.

The Patients and the Relatives

The derivation of the populations who participated in the Camberwell Family Interview and in whom a Disturbed Behavioural Assessment is available are shown below. There are 82 cases with Camberwell Family Interviews and 222 with Disturbed Behaviour Ratings.

Derivation of Patient Samples for Assessments

Total Cases 1st Episodes of Schizophrenia 253

'SC sample derived from 253		DBR sample derived from 253	
uitable:		Unsuitable:	
Living alone	81	None, if no relative patient asked for account	
Immigrant background	36		
Others (rel ill/away)	13		
table cases	123	Suitable cases	253
assessment:		No assessment:	
Relative/pt refused	39	Alone, no account from pt	19
Unrateable recording	2	Pt refused access to rels	6
		Other (rel ill/language)	6
ilable Assessments EE/SC	82	Available Assessments	222
discharged	5	Not discharged	10
ilable EE/SC for outcome study	77	Available DBR for outcome study	212

These 82 cases yielded assessments of 88 relatives, as in six cases both parents were interviewed. The 88 relatives consisted of both parents in six cases, and 46 mothers, 8 fathers, 1 cohabiting girlfriend, 12 husbands, 4 wives, 1 brother, 3 sisters and 1 sister-in-law. Some sociodemographic variables of the patients and their relatives are shown below.

Characteristics of Patients and Relatives with Camberwell Family Interview

Patients: Total 82

Sex : male 48 female 34

Marital Status : single 59 married 16 divorced/separated widowed 16 cohabiting 1

Employment at admission : employed 24 part-time 1 school 2 housewife 9 unemployed 46

Racial Origin/Language/by Patient tabulated for Informants

Patient				Informant
White/English	65	-	59	White/English*
		-	2	Italian
		-	3	Polish
		-	1	Swiss*
White/European				
Greek	1	-	1	Greek
German	1	-	1	English
Asian/Asian	2	-	2	Asian/Asian
Negro/English	9	-	9	Negro/English *+
Mixed/English	4	-	4	White/English +

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* Both parents assessed, 4 White/English, 1 Negro/English, 1 White (Swiss)

+ 7 second generation immigrant patients, 2 immigrant students.

The overlap between the population who had a Camberwell Family Interview and a Disturbed Behaviour rating is shown in Table III at the close of the chapter.

The Analysis

Two separate features of the results were analysed:

1) firstly the relationship between the disturbed behaviour rating and the measures of critical comments and social contact derived from the Camberwell Family Interview were examined. Critical comments were divided at the level of 6 into high and low, and social contact at the level of 35 hours a week, into high and low (Vaughn and Leff 1976). Firstly the level of disturbed behaviour was divided into <1, and >2, and 2x2x2 contingency tables devised. Secondly DBR was divided into three groups, at 0, 1 and 2, and 3 or more, giving at 3x2x2 contingency table. Expressed emotion was divided at <6 and >6 critical comments, and social contact at <35 hours and >35 hours in both analyses. Log linear models were fitted to the contingency tables (Everitt 1977), and in both analyses the model containing all the main effects and interactions was fitted to the cell frequencies, and subsequently reduced hierarchically by eliminating three factor and two factor interactions and main effects. Models were fitted using the computer package GLIM (Baker & Nelden 1978), and the model terms were eliminated only if their exclusion resulted in a nonsignificant ($p>0.05$) increase in the maximum likelihood chi^2 statistic.

2) Secondly the relationship of the measures to relapse were analysed. For each patient the period between discharge and relapse/readmission, loss of contact or the elapse of two years or until the study closed on 1st August 1982 was calculated to the

nearest week. The resulting relapse/readmission time distributions were summarised using actuarial life tables. Comparisons between groups of patients with different assessments were made using the log rank test (Peto 1977). Separate actuarial relapse/readmission free analyses were performed for disturbed behaviour ratings, critical comments, and social contact. Since both maintenance treatment (active v placebo) and the period of time between the onset of the illness and admission (>1 yr, <1 yr) have been shown to have effects upon relapse and readmission (Chapters 5 and 6) the comparisons where performed allowing for these important variables.

The Results

Three aspects of these results are presented in some detail.

Firstly, the findings from the Camberwell Family Interview and the Disturbed Behaviour Rating are presented. The distribution and range of the number of critical comments, the findings of measures of overinvolvement and some details of the relatives who expressed these emotions are described. The division of relatives into those spending less than 35 hours in a typical week with the patient and into those spending 35 hours or more in face to face contact are related to the findings of high or low Expressed Emotion. The findings from the Disturbed Behaviour Rating and some details of the actual behaviour are described.

Secondly, the relationships between the Camberwell Family Interview and the measures of disturbed behaviour are itemised.

Lastly in those patients who failed to achieve discharge the assessments of the home environment are noted, and for those achieving discharge the findings from the Camberwell Family Interview and the Disturbed Behaviour ratings are related to the

occurrence of relapse or readmission.

1) The Findings from the Camberwell Family Interview

The critical comments expressed during the total interview, usually of two or more hours duration, were counted and are displayed in a histogram (Graph 1 at the close of chapter). Five relatives made no critical comments and one relative made twenty critical comments, with a mean score of seven. 50 relatives satisfy the criteria described by Leff et al as expressing more than 6 critical comments and having high Expressed Emotion. 38 relatives are of low Expressed Emotion.

The number of overinvolved comments made were counted, with 76 relatives making no overinvolved comments, 6 making one comment, 3 making two comments, and one relative making three, four and five comments each. The 12 relatives who made overinvolved comments included 9 mothers, of whom one was schizophrenic, one was probably psychotic, one confided that her husband had died in a mental hospital after a prolonged psychotic illness; one was married to a "cured" alcoholic, one had a schizophrenic brother, and one had parted from her spouse when he suffered a paranoid illness; the three other mothers were unremarkable. The three other relatives who made any overinvolved comments were a father, who was concerned that his son was vulnerable to homosexual contacts, and had himself suffered two psychotic episodes with good recovery; one unremarkable father; and a highly bizarre husband who presented the clinical team with a tape-recording of his wife's unusual utterances. Leff has recently suggested that high Expressed Emotion as assessed by overinvolved comments should be lowered from 4 comments to 3 comments. All three relatives expressing three, four and five

overinvolved comments were in any event classed as high Expressed Emotion on the basis of having made 6 or more critical comments (the unusual spouse, the psychotic mother and the possibly psychotic mother).

Social contact in terms of face to face contact between the relative and the patient was noted as greater or less than 35 hours in a typical week preceding admission. Twenty-two patients were in high social contact and sixty in low social contact with their relatives. The 22 patients were high social contact with 13 mothers, 6 husbands, 1 wife, 1 sister and 1 sister-in-law. High social contact does not appear to depend upon the number of people in the household, which was an average of (range 2-11) 3.4 in the high social contact group and an average of (range 2-8) 3.8 in the low social contact group, although the numbers in the household may affect the individual case. The social class based on the occupation of the father or spouse bore little obvious relation to social contact, as 21 of the 60 cases in low social contact, and 6 of the 22 cases in high social contact were in social class I or II.

In 6 cases both parents made themselves available for the Camberwell Family Interview. Mothers and fathers received similar ratings for critical comments, giving two pairs of low Expressed Emotion and four pairs of high Expressed Emotion assessments. None expressed any overinvolvement, although all the fathers were in employment and took time of work for the interview. All the fathers were in low social contact with the patient, and five of the six mothers were. The sixth mother who was in high social contact with her son contended with one of the most disturbed patients we

assessed (disturbed behavioural rating of 12 out of a maximum score of 15) (Appendix patient 162). For the purposes of examining the patients, and their outcome, the home was classed as high or low Expressed Emotion and high or low social contact, the duplicate parents being discounted (the one case where social contact was high in the mother, but not the father, was classed a high social contact home). 7 patients lived in homes with both High social contact and High expressed emotion, 21 in Low social contact, Low Expressed Emotion homes and 15 in High social contact with Low Expressed Emotion. 39 cases had Low social contact but High Expressed Emotion homes (see Table II).

The Findings from the Disturbed Behaviour Rating

The rating of Disturbed Behaviour gave a possible range of scores from 0 to 15. There are ratings available for 81 of the sample with a Camberwell Family Interview, one wife of a pathologically jealous patient saw AG but declined to see the research psychiatrist. There are 212 cases with a DBR assessment who achieved discharge. The overlap between the populations with various assessments is displayed in Table III (close of the chapter).

The table below shows the scores for the 81 cases with a Camberwell Family Interview, and for the population achieving discharge. The revised coding used in some parts of the analysis codes behaviour as absent or present, given a possible score ranging from 0 to 5.

Disturbed Behaviour Ratings: Scores in Cases used to Assess the Home Environment and Scores in Cases who were Discharged

		DBR Score											
	Total	0	1	2	3	4	5	6	7	8	9	12	14
EE Sample	81	12	10	10	14	6	5	10	3	-	6	4	1
Discharged cases	212	39	28	35	45	13	10	18	10	2	7	5	-

		Revised DBR Score					
	Total	0	1	2	3	4	5
EE Sample	81	12	27	19	15	7	1
Discharged cases	212	39	76	50	35	12	0

DBR Score - sum of separate subscales.

Revised: number of separate items scored positive.

The table below shows for all cases rated, those who did and did not display particular behaviours, and separates those who acted unusually infrequently from cases where the disturbance was persistent and occurred for longer than a month. Bizarre behaviour is more common than the other behaviour (68.9% displayed some such behaviour), although 64 of the sample of 222 cases (28.8%) displayed behaviour threatening to their lives, and 21.6% behaved in a fashion threatening to the life of others.

222 Cases with Disturbed Behaviour Ratings, Divided in None, Some and Much

Nature of Behaviour	None	Once or Twice	Repeatedly for > 1/12	Totals
Threatening to life of patient	158	50	14	222
Threatening to life of others	174	33	15	222
Inappropriate sexual	185	21	16	222
Damaging to property	176	27	19	222
Bizarre not otherwise classifiable	69	77	76	222

The benaviour was not usually trivial. Life threatening behaviour included minor attempts, one patient being found in the bathroom making feeble attempts at wrist laceration with nail scissors. More alarming episodes included lying down in the middle lane of a motorway, one patient who attempted hanging and subsequently took a large overdose requiring ventilation, and another who lacerated his throat and required tracheostomy. Behaviour which was threatening to the life of others ranged from an ill organised attempt to hurl an iron bar at a neighbour, based on

delusions of persecution, to a prolonged attack occurring over the course of hours upon a father, the patient believing his father to be the Devil Incarnate.

Sexually disturbed behaviour frequently involved explicit behaviour of young males to their mother or sisters. One 28 year old civil servant exposed himself to the wife of a friend whilst he was clad in a Red Indian suit, another extremely deteriorated patient wandered the house (and subsequently the ward) for weeks clutching his exposed genitals. A married Asian lady, the mother of two young children, divested her sari before her brother-in-law.

Behaviour damaging to property included the bizarre, one lady cuting off all the flower heads in the garden, the extremely violent destruction of the contents of the family living room, including demolition of furniture, to the soiling of beds. Patients not infrequently threw away clothes (one patient discarded all her shoes) and money (the same lady threw away eighty pounds in notes into the dustbin). One patient strangled the pet budgerigar.

It was occasionally difficult to classify behaviour, and the category of bizarre and inappropriate behaviour included such features as absence from home. One patient was returned from Ireland and Japan, having fled his supposed persecutors. Other relatives reported the return of the patient from Europe, Africa, and nearer at hand, Salvation Army hostels a few miles from home. Shouting, swearing and behaviour consistent with the belief that the patient was a cat or dog or more exotic animal was classed here, as was the decoration of the family garden with kitchen utensils and the place of an expensive teapot up a tree. Some mention of these behaviours is made in Chapter IV and in the

Appendix.

2) The relationship between the results of the Camberwell Family Interview and the Disturbed Behaviour Assessments

Disturbed behaviour ratings are available for 81 of 82 patients who had expressed emotion in the home assessed. (This patient with only a Camberwell Family Interview suffered from pathological jealousy and his wife declined to see the research psychiatrists.) (See Table III.)

The relationship between the revised coding and the expressed emotion/social contact assessments are tabulated (Table II) with the disturbed behaviour rating divided into 0; 1; 2; and 3, 4 and 5. The relationships between the three variables of expressed emotion, social contact and disturbed behaviour were statistically examined. Where the level of disturbed behaviour was split into >1, <2, the main effect of disturbed behaviour could be eliminated, leaving a model incorporating only expressed emotion, social contact and their interaction ($x^2 = 3.96$ df = 4, $p<0.4$). Where disturbed behaviour ratings were split into three groups (0, 1, 2, and >3) the main effect of disturbed behaviour could not be eliminated ($x^2 = 20.6$ df = 2 $p<0.001$). This reflects the uneven distribution of patients across these three groups of Disturbed Behaviour (Table II). The statistical analysis is consistent with a model of partial independence ($x = 7.56$ df = 6 $p>0.2$) where disturbed behavioural ratings are not associated with either expressed emotion or social contact. This makes it permissable to collapse the tables, relating expressed emotion and social contact to each other, and discounting the disturbed behaviour rating, without introducing any false associations. High critical comments

are significantly associated with low social contact (x^2_{ML} = 7.72 df = 1 $p<0.01$) irrespective of disturbed behaviour (Table II).

3. The Relationship of Expressed Emotion, Social Contact and Disturbed Behaviour to Relapse and Readmission.

77 of the cases with a Camberwell Family Interview to assess the home environment achieved discharge. The 51 cases participating in the prophylactic drug trial were followed up until relapse, loss of contact, the close of the study or the elapse of two years. The 26 cases receiving 'standard' outpatient care were reviewed at the close of the larger study and readmission severed as the best parallel to relapse. The numbers of cases within these treatment groups, and the measures of Expressed Emotion and Social Contact are tabulated by outcome below.

Numbers of Cases

EE/SC	Treatment	Entered	Well Complete	Lost Cont	Readmission Relapsed	Non Discharged
EE	Active	9	1	2	6	
>6	Standard	14	7	1	6	5
	Placebo	18	4	-	14	
Subtotal	>6	41	12	3	26	5
	Active	14	7	-	7	
<6	Standard	12	9	2	1	-
	Placebo	10	4	-	6	
Subtotal	<6	36	20	2	14	0
SC	Active	5	4	1	-	
>35 hrs	Standard	9	6	1	2	1
	Placebo	7	2	-	5	
Subtotal	>35	21	11	2	7	1
	Active	18	4	1	13	
<35hrs	Standard	17	10	2	5	4
	Placebo	21	6	-	15	
Subtotal	<35	56	20	3	23	4
TOTAL	ALL	77	32	5	40	5

The 5 cases with home assessments who did not achieve discharge in time to participate in the study were case nos 229, 276, 324, 348 and 362 (see appendix). All had relatives expressing high emotion, and all bar patient no 324 were in high social contact with the key relative. They had disturbed behaviour ratings of 14, 3, 3, 6 and 9 respectively, and three of the five cases had behaved in a fashion threatening to the life of others. The outcome at last contact was poor, three cases attending day care, one case at home but still under legal constraint, and one case in a rehabilitative ward for young chronic schizophrenics.

Comparison of the relapse/readmission rates in the low and high social contact groups, adjusted for treatment and period prior to admission does not reveal a significant difference (x^2 = 1.93, 1df, p=0·17 NS). Comparison of high versus low critical comments adjusted for treatment and period of time between onset and admission does not reveal significant differences in relapse/readmission rates (log rank test x^2 = 2.21 df1, p=0·14 NS), but without adjustment for treatment and time relapse rate is higher in the high critical comments group (x^2 = 4.40 df1, p<0·05) This difference is explained by the prognostic factors, the patients in high Expressed Emotion homes including more placebo allocated cases and more patients with a period between onset and admission in excess of one year.

	Treatment		Period between Onset & Admission	
	A/S	Placebo	<1 yr	>1 yr
High CC >6	23	28	23	18
Low CC <6	26	10	29	6

To quantify these non-significant results the hazard rate ratio was calculated, using the Cox proportional hazard model (Cox 1972) incorporating treatment, and the period between onset and admission, using the information from the Critical Comments and Social Contact measures. This gives an estimate of the probability of relapse per week (with 95% confidence limits).

Variable	Hazard Rate Ratio	95% Confidence Limit
Social contact	1.7 (LvH)	0.8, 3.4
Critical comments	1.8 (HvL)	0.7, 4.2

The hazard rate ratio is 1.7 times as high in the low social contact group as it is in the high social contact group, but it

could be anywhere between 0.8 and 3.4. Similarly the hazard rate ratio in the high critical group is 1.8 times as high as in the low critical comment group, but could be anywhere between 0.7 and 4.2. This indicates the difficulty in interpreting non-significant results.

The disturbed behaviour rating was available in 212 cases who were discharged (see Table III). When the original rating was stratified into three groups (0-2,3-5,>6) and actuarial life tables prepared, log rank testing yielded a significant but ambiguous result. Where treatment (active/standard/placebo) was accounted for, it seemed that patients with a middle range of disturbed behaviour (3-5, 68 cases) had a higher relapse rate than those with low (0-2) and high (>6) assessments (x^2 6.74 2df $p \leq 0.03$). This original scale incorporated both severity and the passage of time, albeit only the passage of more or less than one month. This positive result did not persist when the scale was revised to assess only the absence and presence of disturbed behaviour, and comparison of relapse rates in the four groups within the revised coding (0, 1, 2, and >3) indicated no important differences between them ($x^2 = 2.35$, df = 3, $p = 0.50$). When adjustment is made for maintenance treatment and the period between onset and admission no significant differences were revealed ($x^2 = 1.80$, df = 3, $p = 0.62$).

Summary

The Camberwell Family Interview, with 88 relatives of 82 first episode schizophrenic patients revealed little over-involvement but

more than half the relatives expressed critical comments sufficient to class them as high Expressed Emotion relatives. Social contact was low with three quarters of the relatives, and high criticism is associated with low contact, irrespective of behaviour disturbance as assessed. None of the assessments could be demonstrated to bear a clear relationship to relapse and readmission, in contrast to treatment after discharge and the elapse of time between onset of the illness and admission.

Discussion

The inverse relationship between expressed emotion and social contact would suggest that at this early stage of the illness the key relative spends more time with the patient who is not criticised for his/her behaviour. Where the behaviour is intolerable to the relative, social contact is likely to be low. Over-involvement appears rarely in this youthful sample of patients and is found predominantly in mothers, and those with close experience of mental illness, as in previously reported studies (Kuipers 1979).

The selection of these cases is worthy of note. Only one third of the potential sample was assessed by Camberwell Family Interview. This one third may not be typical of the total population, but a number of patients and families who did not collaborate in the drug trial did assist with the family interview.

It is perhaps disappointing that neither Expressed Emotion (in terms of critical comments) nor Social Contact nor disturbed behaviour related to relapse. Previous work by the MRC Social

Psychiatry Unit and others gave hope of an additional tool to be used to improve the outlook for schizophrenic patients. While it would appear from these results that intervention to reduce critical comments or social contact is unlikely to be useful in lowering relapse, may be helpful to patient and family to have opportunities to express their fears and hopes for the future and to come to an understanding of the nature and effect of major psychiatric illness. None of the assessments could be clearly related to relapse over a two year follow up period. Whilst all studies inevitably involve selection of cases, the cases who did not enter the double blind drug trial could serve as a comparison group, using readmission data collected at the close of the study. Finally, these cases were drawn from a range of clinical and social settings where the assessment of relapse and readmission could remain entirely blind to the assessment of the home environment by the Camberwell Family Interview.

TABLE I

Rater Reliability : Camberwell Family Interview EE Ratings

		MRC Social Psych.		Research Worker		
Tape No	Pt No	EE	Category	EE	Category	
1	008	10	H	6	H	
3	013	10+	H	9	H	
4	015	1	L	3	L	
6	026	1	L	0	L	
8	035	4	H	3	L	*
9	028	0	L	1	L	
18	077	0	L	0	L	
24	085	1	L	1	L	
43	147	6+	H	9	H	
45	153	10	H	17	H	Organic illness
52	190	4	L	5	L	
54	209	0	L	4	L	

The original work with the Camberwell Family Interview took a level of 6 as a cut off between high and low EE. Later work used the cut off at 4 critical comments. This accounts for the only discrepancy in the reliability of the ratings.

TABLE II.

Distribution of Patients by Disturbed Behaviour Rating (DBR) and Expressed Emotion

		Social Contact		Total
		<35h	>35h	
DBR = 0				
Critical	<6	4	3	7
Comments	>6	5	0	5
DBR = 1				
Critical	<6	6	6	12
Comments	>6	14	1	15
DBR = 2				
Critical	<6	6	4	10
Comments	>6	8	1	9
DBR = 3,4 or 5				
Critical	<6	4	2	6
Comments	>6	12	5	17
Total				
Critical	<6	20	15	35
Comments	>6	39	7	46

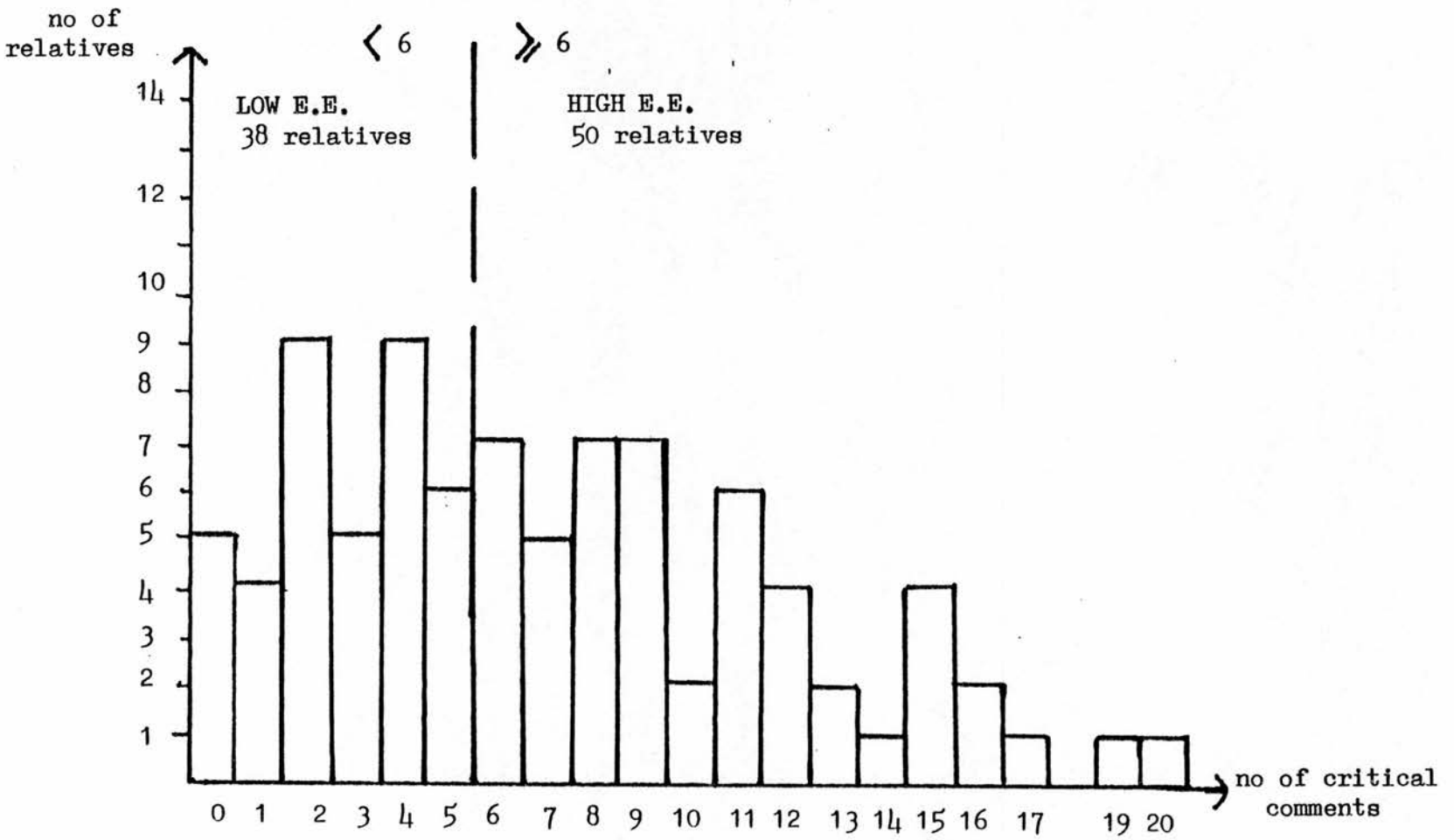
TABLE III

Overlap of EE/SC and DBR Assessments, related to treatment after discharge, and noting non-discharged cases

	Treatment Status After Achieving Discharge				
	Prophylactic Drug Trial Entrants		Trial Eligible		
	Active	Placebo	Standard	Not Discharged	TOTALS
EE/SC and DBR	23	28	25	5	81*+
EE/SC only	-	-	1	-	1*
DBR only	31	38	67	5	141+
Neither EE/SC nor DBR	-	-	23	7	30
Totals	54	66	116	17	253

** Total EE/SC assessment 82 Discharged Cases 77
++ Total DBR assessment 222 Discharged Cases 212

Critical Comments from Camberwell Familly Interview.



CHAPTER X

Discussion

The present study arose from an effort to evaluate the benefit of prophylactic neuroleptic medication following a first schizophrenic illness. The answer to this central question is incomplete. Whilst a clear advantage in terms of a lower relapse rate is associated with active maintenance neuroleptic medication, twenty per cent of the original sample did not experience relapse despite placebo maintenance medication. This finding confirms the findings of previous workers who demonstrate the benefit of prophylaxis for schizophrenics as a whole, (Davis 1975; Schooler 1979). Despite the fact that this sample suffered only one episode of illness, the number of cases which remain relapse-free while allocated to placebo maintenance is similar to that quoted by Hogarty, who followed a more heterogenous sample of schizophrenics for two years, (Hogarty 1974, ii, iii).

In the current study forty-one cases completed follow-up and remained relapse free; of these eighteen were maintained on placebo. (Incomplete follow-up was obtained in six cases allocated to active medication and seven cases allocated to placebo.) These eighteen cases exhibited a period between onset of the illness, and discharge from the first hospitalisation, which was less than one year. All other placebo allocated cases which relapsed underwent durations of illness in excess of one year. Examining the forty-one cases across the variables of duration of total illness and treatment allocation demonstrates the discrepancy in the distribution:

41 Cases No relapse Complete follow-up		Duration of Total illness (onset to discharge) >1yr	<1yr	Totals	All Cases
	Active	5	18	23	54
	Placebo	0	18	18	66
	Total	5	36	41	120

Kane (1982) performed a similar study of prophylaxis following a first schizophrenic illness in 28 cases. The selection criteria included a time lag between onset and admission not to exceed three months, and the achieving of a stable remission within one year of hospitalisation. Although this suggests a bias in the direction of brief total duration of illness for these cases, some cases had a period between onset and discharge in excess of one year (personal communication). The Research Diagnostic Criteria (Spitzer et al., 1975) defined the cases as schizophrenic (19 cases) unspecified functional psychosis (3 cases), other psychiatric disorder (4 cases) and schizotypal affectives (2 cases). The Research Diagnostic Criteria, like the Present State Examination (Wing, Cooper et al., 1974), lays more weight upon the presence of symptoms than their duration, and neither criteria exclude nor require very prolonged disturbance of the mental state. The results are complicated by a very high attrition rate, 35% of the sample failing to complete the one year follow-up. Nonetheless Kane found seven of the seventeen placebo allocated cases experienced relapse, while none of the eleven active allocated cases relapsed. Analysis of survival curves based on analysis of life tables, just failed to yield a statistically significant result in favour of active

treatment (0 = 3.57, 1df p = 0.059 Lee Desu statistic) (Garmezy, 1965). A similar result from the present study in which the crude effect of active versus placebo medication just failed to reach statistical significance (chi^2 = 5.59 1 df p = 0.058) altered considerably when the effect of the total duration of illness was introduced as a factor.

The effect of time and its relationship to outcome is not generally taken into account in studies where relapse is the major variable under consideration. The present study of first episode patients does not yield a larger population of patients who remain relapse-free while allocated to placebo than other studies, such as those of Hogarty (1924, ii) and Leff (1971). There is no evidence in these other studies that an excess of first episode patients are found in the small number who remain relapse free, allocated to placebo. It may be that stratification by the period between onset and admission could be usefully added to the usual stratification of samples by age and sex and socio-demographic variables which occur in examination of doubleblind drug trials of neuroleptic medication.

Hogarty (1974, ii) examined the post hospital adjustment of the twentyeight cases in his study, which compare with the eighteen relapse-free placebo maintained cases in the present study. He had the opportunity to examine the effect of drugs and of major role therapy, the latter consisting of social casework and vocational counselling. He argues in favour of the use of drugs in view of the high relapse in their absence, and feels that although the placebo maintained survivors display less symptomatology, management measures in this group are only of theoretical interest.

Management in the present study lay in the hands of the

responsible clinician, and spanned a wide range, but no valid assessment can be made in the eighteen relapse free placebo cases. Details of this unusual group are tabulated, and they are representative of the 120 trial entrants in terms of age (range 17 to 56, mean 26.3 years), sex (10 males, 8 females) and race (13 white European, 3 West Indian, 2 Asian cases). Only one, with a follow-up of nine months, is unemployed. As a group those with follow-up approaching the full two years are remarkable for their post hospital adjustment. The family histories of mental illness span the widest range, half the cases having no known family history (9 cases). Two cases had first degree relatives with histories of alcoholism, two had affective family histories, and two had schizophrenic relatives. Patient 163 acquired a family history by the close of the study when his sister came to treatment for an illness very similar to his own, and one Asian patient was brought early to medical attention, her spouse recognising her to be suffering an illness similar to that of his own brother. Patient 114 knows nothing of his father, but his sister is seriously promiscuous, and his brother committed murder at the age of 15 years.

Placebo Maintained/Complete Follow-up No Relapse

Case No	Age	Sex	Race White/ Black	Duration Follow-up Months	Occupation at Admission	Details	Family History
007	20	M	W	24	Undergraduate	Achiever	Affective
019	18	M	B	24	Factory work	Achiever	-
037	22	F	B	24	Secretary	Achiever	-
061	25	F	W	24	Administration	Achiever	Alcohol
071	34	M	W	24	Bricklayer	-	Alcohol
085	28	F	W	24	Musician	Achiever	Affective
102	37	M	W	24	Lecturer	Achiever	-
111	44	F	W	24	Housewife	-	-
114	18	M	W	24	Factory	Possible achiever	Psycho-path
121	24	F	W	24	Secretary	-	-
154	27	M	W	20	Librarian	-	-
163	25	M	B	24	Dustman	Possible achiever	Late schizo
190	17	M	W	23	Apprentice	Achiever	Schizo
297	25	F	B	9	Housewife	-	by marriage
321	22	M	W	12	Factory	-	-
329	39	F	W	12	Secretarial	-	-
340	24	M	B	10	Unemployed	-	-
350	56	F	W	10	Housewife	-	Schizo

Although the group contains the gifted and privileged, one graduate from a favoured social background, and two other

graduates, it also included a dustman and a youth whose factory work consisted of sweeping the factory floor. If one succumbed to the temptation to retrospectively weigh the diagnosis in favour of affective illness it is likely only to exclude patients Nos 007 and 085. Patient 102 had no insight into his presenting complaints even at the two year follow-up, but made achievements despite the persistence of his encapsulated delusions.

Two of the cases from Kane's study of first episode patients were withdrawn from the study because of toxic effects of neuroleptics. In the present study two of the 120 trial entrants suffered from complications of neuroleptic treatment. Patient 069 developed spontaneous involuntary movements of her lower limbs sufficient to induce weight loss after one year of maintenance treatment. Patient 286 developed almost incapaciting akathisia early in acute treatment, and later developed copulatory movements. Patient 069 was maintained on active treatment, and patient 286 relapsed early on placebo medication. In both cases drug intolerance compromised their further management. Two other cases appeared to the author to be at some disadvantage due to maintenance treatment, but both in fact were maintained on placebo medication. Patient 108 complained of inner restlessness, spasm of the neck muscles and involuntary fixation of her eyes upon the ceiling, these experiences occurring infrequently during the year between discharge and relapse. Patient 163 complained of loss of interest and difficulty in achieving sexual satisfaction. The author erroneously attributed the undoubted sexual successes of the patient after one year, to reduction of the medication to the minimum required by the study. Persistence of extrapyramidal symptoms after neuroleptic

withdrawal has been reported (Hershon, 1972), and in these latter cases if neuroleptics are implicated it must be in respect of the acute treatment.

The present study largely neglected events during hospitalisation, but all cases were exposed to neuroleptics, and of the 253 cases examined two cases received Lithium salts and four cases had courses of electroconvulsive therapy. Perhaps the infrequent use of electroconvulsive therapy supports the views of Harris (1954) and M. Bleuler (1978) in their comments upon the relative paucity of the most gravely ill schizophrenic cases presenting in recent decades.

However in this sample there is a small population who do not achieve early or full remission. 10.2% of the population required protracted hospitalisation or required extensive further support in hostels or day care. Within this group are some of the most disabled, and underprivileged and occasionally dangerous. Patient 041, a violent recidivist from a very deprived social background was transferred to a special state hospital for the criminally insane, from this, his first admission. Patient 020 took her life after two years continuous hospitalisation, her positive psychotic symptoms little alleviated by heroic treatment measures. Patient 281 achieved discharge and is not contained within this 10.2%. The author was not able to review this patient, a telephone call to her father establishing that the patient remained at home, virtually housebound, deluded and aggressive, her screaming abuse clearly audible in the background. Patient 047 similarly has not been institutionalised, but remained very limited, and repeated recurrence of positive symptoms would occur with minimal stress,

such as attending an art class. The limitation of the lives of schizophrenic patients has been related to the effects of institutional care by Wing (1970). Poverty as a facet of chronic schizophrenia is eloquently described by Morgan (1979) who doubts that the advent of community based care will abolish the production of such disabilities. Johnstone (1981) has suggested that the deficits seen in the chronically institutionalised may be found within the discharged population. McReadie's (1983) survey of new chronic patients in Scotland indicates that young schizophrenic patients at their first presentation are not immune from protracted hospitalisation, although such patients are outnumbered by organically impaired patients.

The events leading to hospitalisation have been described in Chapter IV. The relationship of time to outcome increases the interest in this period. It seems that the increase in the number of patients achieving discharge has not resulted from earlier presentation, even supposing that earlier presentation would improve prognosis. Clausen (1955) reported the difficulties associated with admission, in the 1950's, largely from the accounts of wives of functionally psychotic men, and Creer and Wing (1974) has drawn attention to the difficulty relatives report in obtaining aid. In the present study the overwhelming impression was that accounts from relatives were rarely sought and the onus of cooperation lay in the patient's hands. While clinical practice in other fields requires and expects the patient to seek attention when necessary this is much less applicable when the patient suffers a psychotic illness. The spirit of the Mental Health Act 1959 may be interpreted as placing decisions concerning hospital and medical

care in the hands of the nearest relative, who makes a first approach by completing an application, which may be supported by informed medical opinion. Relatives were sometimes unaware of this provision, even in the face of social worker contact, and the author was sometimes the only medical practitioner the relatives met. Rwegellera (1980) reported on the routes to hospitalisation used by a population from South London. He matched a West Indian and Asian population with an English population by socio- demographic and diagnostic variables, and found the West Indian population to be more often brought to hospital by the police or the Mental Welfare Officer. There is no clear evidence that such patients had not at some stage contacted their general practitioner, and the details of disturbed behaviour are not given. He reports that disturbed behaviour was more prominent in the West Indian, and to a less marked extent, the Asian population. In the present study disturbed behaviour as recorded cannot be clearly demonstrated to be excessive in the first and second generation of immigrants, but the ratings are crude, and no assessment of private (in the home) as opposed to public disturbance is attempted.

Disturbed Behaviour Rating

Each behaviour positive/negative

No Cases	0/1	2	3	4/5	Totals
'White'	81	38	24	8	151
'Black'	39	15	15	3	71
Total	119	53	39	11	222
% Cases					
'White'	53.6	25.2	15.9	5.2	100%
'Black'	53.5	21.1	21.1	4.2	100%
Total	53.6	23.8	17.5	4.9	100%

The disturbed behaviour assessments did not have any apparent effect upon the emotions expressed by relatives concerning the patient, as assessed by the Camberwell Family Interview (Rutter and Brown, 1966). The examination of the home environment yielded no effect upon relapse in this population, although only one third of the 253 cases were able to participate in this aspect of the study. The attention of the family after discharge often paralleled their interest in seeking attention for the patient, and it is the co-operation of the relatives that yielded the most information as to outcome for those cases who did not participate in the prophylactic drug trial.

This present study may be criticised in many ways. The selection of the cases rests heavily upon the clinicians' concept of schizophrenia, although in three centres the author attempted to screen all new admissions. While the sample may not reflect the most stringent definition of schizophrenia it does represent that

population in whom the question of prophylactic medication is raised in a clinical setting. The lack of attention to the period of hospitalisation makes it impossible to relate acute treatment to later outcome. Although this account may be considered excessively anecdotal, diagnostic and clinical criteria change, and the effort to describe this population may permit others to draw their own conclusions from details of actual events.

In acordance with Kane (1982), there is no evidence from this study that a first schizophrenic illness has of itself a good prognosis. However, for the individual case, a patient may occasionally defy all outcome criteria, and override the apparently poor prognosis associated with late presentation and unemployment (patient 107) the effect associated with a family history of schizophrenia (patient 190) and the disadvantages of social deprivation (patient 037).

Sir Aubrey Lewis felt that psychotropic drugs had a minor role when compared to rehabilitative services and changes in social management for the mentally ill (Lewis, 1959). The search for an optimal duration of hospitalisation may reflect this change. Glick (1974) found brief hospitalisation of three weeks to produce a less satisfactory outcome at one year for schizophrenics than hospitalisation of two or three months. In other societies it is suggested that care within the extended family is better than the outlook associated with nuclear families (Fakhr-El-Islam, 1979). In this later study of a large sample of first episode schizophrenics, 67% of the cases from extended families had only one month of illness preceding intervention, as opposed to 54% from the nuclear family setting. This may be related to the better outlook

apparently associated with an extended family setting, and tempts the author to suggest that early intervention might be a suitable area for efforts to alter the care of the mentally ill. Such speculations may be spurious. The effect within the nuclear family in western society of caring for a schizophrenic relative include financial burden and social difficulties (Hoenig 1966, Kuipers 1979). The measures of expressed emotion in this study did not relate to relapse, but the MRC Social Psychiatry Unit link relapse with high expressed emotion and high social contact (Leff and Vaughn 1981, Leff and Kuipers 1982). It may be that these measures reflect changes in the home in response to the family burden.

Despite changes in hospital care, rehabilitative measures and the move towards community care, active maintenance medication has much to offer schizophrenics. The hazards, associated with these drugs of prolonged extra- pyramidal symptoms and irreversible tardive dyskinesia (Hershon 1972, Simpson 1978) cannot be discounted. Neither can the serious nature of the illness itself with the potential for relapse, readmission and social disruption, be minimised.

While a strategy may be adopted, prescription of medication is not equivalent to its acceptance, and it is the author's strong impression that the maintenance of contact may be usefully continued regardless of the use of prophylactic neuroleptics.

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1 JS 29 years Male Caucasian Trial Entrant

This handsome youth of Greek origin was admitted suffering from an illness characterised by the belief that forces of evil were trying to kill him. He made a slow recovery and subsequently lived with his brother, a diplomat. He remained unemployed and lacking in volition, having held a clerical post prior to his illness. Six months later he relapsed, believing cameras were watching him and rooms were bugged. After a slow recovery he was repatriated.

His aunt died in a mental hospital from diabetes, having been under prolonged care for schizophrenia.

2 GDW 30 years Male Negro Eligible

Admitted from his sister's house, floridly disturbed, the patient had been behaving oddly (barking like a dog on his hands and knees) for some months. On admission he was grossly thought-disordered and preoccupied with ideas of bodily change. He had previously held many brief unskilled jobs.

Contact was lost when the patient, within weeks of discharge, left for Birmingham to join other siblings, members of a well-known popular musical group.

3 BW 44 years Male Caucasian Trial Entrant

The patient had been disturbed for some two years or more but had not consented to voluntary admission and had not qualified for compulsory admission. He lived with a brother, his elderly father

and his mother, who had been incapacitated by a series of cerebrovascular accidents. After compulsory admission, subsequent to an episode of directed violence, he made progress on depot medication. After two years he remains free of hallucinatory voices and is keen to persist with the medication but remains unemployed and wary of further hospitalisation.

4 DL 39 years Male Caucasian Trial Entrant

An ex-seaman, the patient was admitted after a domestic dispute when he threw the television out of the window. The incident was based upon the complex delusional network with auditory hallucinations of the "Gypsy Sea Queen" saying "We'll get you". The patient improved rapidly, but was now homeless and unemployed. He obtained a residential post locally and remained well on depot neuroleptics. By questionable methods the patient acquired a Seaman's ticket and returned to his profession, remaining in contact informally to the present. At two years he was still working and drug free.

5 CP 19 years Male Caucasian Trial Entrant

This undergraduate, reading engineering in an august university, became distressed at home. On admission he was grossly thought disordered, overactive and hallucinated. He described lucidly disorders of possession of thought. His slow and partial recovery was followed by six months in a Richmond Fellowship Hostel. At one year he relapsed, but made a recovery. He still

occasionally experiences positive symptoms but at two years is taking examinations to become an optician, following a three month rehabilitation course.

6 PV 16 years Male Caucasian Trial Entrant

This schoolboy became floridly disturbed over a few days. His gross thought disorder subsided and he described delusions involving devils, and some magical forces. His illness was slow to respond and his lack of volition was marked. He did not return to school. After protracted partial day care he relapsed and made suicidal gestures. Later he described similar delusions but during these episodes was grossly withdrawn. He remains at home in fair health, and is now drug free and has a normal affective response.

7 JB 21 years Male Caucasian Trial Entrant

While an art student at a polytechnic, the patient was noted to be overactive and excited by his father. Two weeks later the patient returned home, became agitated, sleepless and went missing. The police found him and he was hospitalised. On admission the patient was preoccupied with the occult, religious theories, and believed his personality had been replaced by others. He had tactile hallucinations and visual misperceptions.

He made good progress and was a popular and outgoing patient. He returned to his studies under psychiatric supervision, graduated, and finally stopped his medication. He remains at two years entirely normal and drug free.

He has a strong family history of psychiatric illness (uncle, aunt and father).

8 PCJ 32 years Male Caucasian Eligible

After failing to eat anything bar sandwiches for some months the patient was admitted. He expressed some ideas of reference and the single fixed delusion that he was in his childhood and constantly acted on this belief, attempting to play with children in the street, throwing tantrums, speaking childishly. He was briefly discharged after some months but was readmitted following serious weight loss induced by a diet exclusively of milk and rusks. He remains in hospital care, unaltered by treatment.

The patient's mother presents as a bizarre lady, dressed in primary colours in an odd style, such as red knee high socks. She has been treated many years ago for depression and in these records the patient PCJ is described as the successful child living in digs and holding a steady clerical job.

9 ME 16 years Male Asian Eligible

The patient was admitted, greatly thought disordered and overactive. He expressed a mass of delusions and hallucinations containing supernatural forces, death and killing. His family had been forced to lock him in the house prior to his admission. He made very slow progress and was discharged improved but still psychotic. The arranged marriage prior to his illness has ended. He remains unemployed and has not returned to school.

His sister has been treated for a relapsing schizophrenic illness at the same hospital.

10 MB 47 years Female Caucasian Trial Entrant

Miss B worked unskilled in a factory and lived a frugal life, despite some personal wealth. Her social contacts were limited. Following self-referral the patient was admitted, suffering from auditory hallucinations commenting upon her actions. She believed this to be the work of Satan and that she would be killed by the Yorkshire Ripper.

Following discharge, Miss B persisted with her full-time work and her isolated life style. She attends Outpatients, poorly kempt in brightly coloured, unusual clothes and running shoes, and co-operates with medication. She denies any positive symptoms at two and a half years following her first episode.

11 CC 23 years Female Negro Trial Entrant

Nine weeks following a termination of pregnancy the patient was referred by the Samaritans. Initially the patient ran screaming from the ward, and experienced the belief that her consort was controlling her and putting thoughts into her head. The patient attributed this to telepathic and magical forces. These ideas faded to be replaced with bizarre and hypochondriacal delusions that bubbles were coming out of her skin. During the ensuing two and a half years, the patient was not out of inpatient or daypatient care for longer than four weeks. Recently her mental state has become

within normal limits, but the patient, who has a child aged seven, continues to have serious social problems and is unemployed.

12 BD 26 years Male Caucasian Eligible

The patient was admitted, dramatically paranoid, convinced that cigarettes with poison in them had been deliberately sold to him and that he had a spider in his stomach that would kill him. He was unco-operative, hostile and terrified. His illness has pursued a protracted course, with repeated admissions under various sections of the Mental Health Act, and involving transfer from the district general unit to the more secure local large mental hospital.

He had for some years been truculent and difficult at home, with a very poor work record but by his family's account, he became psychotic only months prior to the first admission.

13 LK 18 years Female Caucasian Trial Entrant

This daughter of a well-known and deteriorated chronic schizophrenic had worked in a factory for a year prior to her admission. She believed that the surgeon had interfered with her and had implanted an electronic device during a recent appendicectomy, and was auditorily hallucinated. After repeated hospitalisation over eleven months, she went to a hostel and was maintained outside hospital for a year.

The patient has since been re-admitted for a further three months and remains unemployed. Attempts to reduce her large doses

of depot medication are met with an increase in positive symptoms.

15 JG 24 years Mixed Race Trial Entrant

On admission the patient believed that she had been reborn as the Virgin Mary and that Satan and a dead popular singer were controlling her. She described thought insertion and hallucinations in all sensory modalities and was grossly perplexed.

Premorbidly the patient had done well at school, worked as a telephonist receptionist and occasionally as a model. Four months prior to admission her husband had noted her to be periodically hallucinated.

The patient absconded but later co-operated with treatment and was entirely well and working. Nine months later the patient relapsed, believing Satan was in telepathic communication with her. She refused treatment but was admitted four months later to another hospital, having taken an overdose. Her husband was not prepared to contemplate compulsory admission. Contact was subsequently lost.

17 FJ 21 years Male Caucasian Eligible

Born of mixed English and continental parentage, the patient had attended child guidance and a special school. He was admitted via the Police having been wandering. He was dishevelled and silent. At interview he corrected the spelling of his name and then remained silent, eating an apple. He remained aloof and unkempt but he established himself at table tennis. Eventually he revealed a mass of delusions and thought disorder:

"The purpose of all knowledge is my category".

"If a person jumped from being into not being there might be more credibility in the coal".

He was discharged, refusing all medications, and came to readmission 18 months later. He has never been employed.

18 CU 27 years Female Negro Trial Entrant

A year prior to admission, the patient, a registered nurse, accompanied her husband to Britain so that he might receive postgraduate medical training in surgery. Two weeks following the delivery of her first child, the patient began to express the idea that the television was referring to her. She claimed the house was burgled and accused her spouse of hypnotising her, and assaulted him. During her husband's brief absence she ran screaming into the street and locked herself into a storage vehicle. Admission was achieved under Section 136 of the Mental Health Act.

For some weeks the patient was affectively incongruous, expressing delusions of reference, often with sexual themes. After improving and transfer to the local Mother and Baby Unit, the patient was discharged on oral medication. One month later, re-admission followed upon florid psychotic features involving fears of poisoning by relatives and friends and religious and sexual themes interwoven in ideas of reference.

The patient returned to Africa when fit to travel one month later.

19 DW 21 years Male Negro Trial Entrant

For two weeks the patient's mother was concerned that he was uncharacteristically quiet. He began to talk to himself and was involved excessively with religious themes, withdrawn, but continued to work in his factory job. Admission under Section 25 of the Mental Health Act was implemented after an episode of tearfulness, overactivity and agitation. During his admission, he expressed the delusion that he was shrinking in size and described supernatural communications with God in the form of auditory hallucinations. His mood was one of perplexity.

He made a good rapid response to neuroleptics and following discharge was most co-operative.

At two years the patient was charming and spontaneous with good insight into his psychotic experiences. He works full time and now cohabits with his young lady and a child of this union is expected. There is no evidence of any defect on examination, nor by the patient's and his family's account.

20 CG 19 years Female Caucasian Eligible

When aged 16 years the patient worked as a shelf filler in a supermarket for six months. She terminated this employment on the grounds that others were jealous of her. During the next 18 months she rarely left her home, and in the weeks prior to admission became personally deteriorated to the extent that she failed to cope with menstruation.

Mental state examination revealed true auditory hallucinations

commenting on her thoughts and actions. The patient believed she was under the influence of witchcraft. Her conversation was bizarre - "When I was at home I had a ghost in me and I was pregnant".

"I look at black and blink to prove I'm not a witch".

The patient's maternal aunt and grandmother have been under psychiatric care.

The patient remained in hospital, her psychotic illness minimally altered by large doses of neuroleptics, but took a fatal overdose whilst on weekend leave two years after admission.

21 AM 52 years Female Caucasian Trial Entrant

Apparently in response to the stress of divorcing her alcoholic husband, the patient was admitted having taken an overdose. Mental state examination revealed a florid paranoid psychosis. The patient believed a special position in the Land Registry was awaiting her, and that thoughts were inserted in her mind and her own thoughts read by a transmitter in her clothes. An empty orange carton on the train indicated to the patient that she must leave immediately. The patient made a good response to neuroleptics and remained socially very well preserved. At six months she had an episode of imperative auditory hallucinations but did not require re-admission. At 12 months she was re-admitted briefly. The patient continues to work in a clerical capacity and to be a social support to her ex spouse.

22 DY 40 years Male Caucasian Trial Entrant

DY worked as a gardener with his brother for some years, and lived in lodgings. He pleaded with his landlady to kill him and threatened to jump off the balcony. His family had noted him to be more isolated for a year, but he had life long bizarre behaviour. On admission he complained of auditory hallucinations and believed that Spaniards would kill him because he was a gypsy.

After a fair response to neuroleptics he returned to the family and to work. He refused depot medication. Two months subsequently he was found dead in the bath. The coroner returned an open verdict. The cause of death was asphyxia due to drowning.

25 SK 24 years Male Asian Trial Entrant

The patient was studying for a diploma in production engineering and also worked part-time as a waiter. He became acutely disturbed and came to admission after the intervention of his landlord. He believed that others thought him a guilty man and were accusing him of raping girls, and the laughter on the radio referred to the way he was sitting. Burgess and MacLean were included in his widespread ill-formed delusional network.

He made fair progress after brief hospitalisation. He remained on oral medication for two years, and has not returned to his studies. He complains of loss of emotional tone and is socially withdrawn, but continues to work as a waiter. He has good insight and no psychotic features but lacks volition and spontaneity.

26 JW 17 years Male Caucasian Trial Entrant

Since an episode of infectious mononucleosis two years prior to admission, JW had suffered from brief periods of a few days of excessive sleep, associated with occasional transitory odd ideas such as that she was in another country or that her parents might be dead. JW also developed an increasing preoccupation with religion, out of context with her family background.

Ten days prior to admission, JW was not sleeping at all by night, insisted on all the windows being kept open and was expressing bizarre medical complaints.

On admission, although normally dressed, she was fidgety and restless, wandering in and out of the interview room. She held people's hands and occasionally slumped across the table or lay on the floor. Her affect was extremely changeable, ranging from laughter to coyness with outbursts of tears, with frequent incongruous smiles. Her thought and speech were difficult to follow. She expressed the idea that she was the Virgin Mary, and believed that she smelt. She believed that people on television were doctors and had a mass of delusions of reference and misinterpretation that she believed represented the voice of God. She made incomprehensible statements such as "Don't cry Mum. I get hot. I cry when you get hot".

JW responded to hospitalisation and oral pimozide and was free of abnormal thought content within two weeks. After a period in day care, when she experienced some intermittent delusional ideas, her affect became within the normal range.

The patient returned to her employment as a secretary and

continued to pursue her many interests and hobbies. After 22 months of outpatient attendance the small dose of pimozide was stopped, and within days JW once again experienced the belief that she was the Virgin Mary. Recovery was once again rapid, and some months later JW successfully stopped her oral medication.

27 DT 27 years Male Caucasian Eligible

The patient failed to sit for his final examinations for a BA in history. After some weeks of social disruption he was seen by the psychiatric services in prison and transferred on Section 60 of the Mental Health Act.

He described auditory hallucinatory voices shouting abuse at him and believed that electrical forces moved his limbs against his will. The faces of others turned into the faces of wolves and he described thought insertion and passivity experiences involving the deity.

After protracted hospitalisation and convalescence at home, he has begun a polytechnic course. He has been free of medication for one year and remains fairly well.

28 MM 20 years Male Caucasian Eligible

Having taken a year off from his undergraduate studies in Social Science, the patient was working in an unskilled capacity. He was admitted having cut his wrists, but left after two days, and was later admitted to intensive care having cut his throat. He attempted to stab himself, and was transferred to psychiatric care

with his tracheostomy tube in situ.

He described widespread fixed delusions involving the police, imposters and plots to cause his death and 'frame him" as a rapist. He continued to make suicidal bids feeling he was in any event due to be killed.

On discharge he had partial insight and partial delusions. After eighteen months he left the country to visit relatives abroad. He had been working unskilled for some months.

30 MG 27 years Male Negro Trial Entrant

For some weeks the patient's family had sought guidance from social services, the police and family doctor. The patient was admitted under Section 136 of the Mental Health Act, having been unwell for months. He described a mass of psychotic ideas involving supernatural power, telepathy and hallucinations:

"I can hear them laughing, see them smiling, but get it in the wind, like a transparent, they're sending a picture of speech".

"I can shake the moon with a stick in my hand and make the sun spin".

"...a nasty horrible smell, like they want to poison your whole system".

"...most of the time the force is controlling me".

The patient took an early discharge and contact was lost seven months later.

31 PW 24 years Female Chinese Trial Entrant

The patient had joined her divorced mother (a restaurant owner) and for one year there had been concern over her isolated withdrawn state. The patient displayed aggressive outbursts and was admitted to day care. Mental state examination revealed imperative auditory hallucinations which the patient believed to be due to psychic forces. She felt names repeatedly found in the newspaper referred to her and believed a camera surveyed her. Situations seemed designed to test her and she complained of intermittent olfactory hallucinations.

The patient refused further attendance and remained at home on oral medication. She spent most of the day in bed, was distant and at times hostile.

One year later the patient was admitted elsewhere following further aggressive outbursts.

The patient's father had been treated for schizophrenia characterised by auditory hallucinations some years ago.

32 BD 54 years Female Caucasian Eligible

This garrulous widow was admitted via the Outpatient Clinic. She described hallucinations calling her a 'silly ignoramus' of one year's duration.

She believed her thoughts to be picked up by a transmitter in the telephone, the radio commented upon her actions and there was a plot to turn her into a spy.

The patient took an early discharge but came to re-admission

after four months. Nine months subsequently she remained unwell, and contact was lost.

33 RD 21 years Male Mixed Negro Caucasian Eligible

This semi-skilled worker lived with his wife and her two children. Following a few days of restlessness, when he was up all night, he became acutely disturbed. He spoke on religious themes, believed his father was controlling him via a voodoo doll and everything he touched felt wet. He wore a piece of string around his waist, referring to it as his life.

Following admission, he discussed his belief in personal commands from God and his religious purpose. At interview he removed all his clothes and attempted to leave through the window. Treatment with ECT and phenothiazines was followed by discharge and the patient returned to work. Contact was lost one year later, but his employer contacted the psychiatric services after that.

34 MK 43 years Male Asian Trial Entrant

The patient worked full time as a boilerman supporting his wife and four children. He became acutely unwell and his foreman organised admission. At intervals he was grossly perplexed and unable to convey his ideas. He later described hallucinatory voices coming from his own throat.

After discharge he was unable to tolerate depot medication due to akathisia, but relapsed on oral drugs at six months. He described feeling that people at work were against him but had

insight into this. He was not auditorily hallucinated but had entertained ideas of self harm. His family had noted his anxiety and sleep disturbance. A year after discharge his symptoms recurred but the patient now remains well and working more than two years after his initial episode, maintained on depot neuroleptics.

His brother had suddenly committed suicide many years ago.

35 DR 16 years Female Caucasian Eligible

This disturbed girl had been under the care of child psychiatrists since the age of ten. She had spent some eighteen months in residential care in Ireland.

The patient was admitted under Section 25 of the Mental Health Act after wrecking her home. She described visual misperceptions and tactile, visual and auditory hallucinations of a group of popular singers. She spoke in an American accent and complained that others called her "punk" and "whore". Her behaviour remained disturbed.

Her repeated admissions were protracted and her management complicated by social difficulties. The family returned to Ireland one year after the initial admission.

36 IM 21 years Male Asian Trial Entrant

The patient lived with his extended family and worked unskilled in vehicle manufacture. Over three weeks he became disturbed, jumped out of a moving vehicle and banged his head purposefully against it. At home he tore up 50 pounds and then attempted to

strangle the pet budgerigar.

After voluntary admission he described auditory hallucinations of his family in Pakistan. He made fair progress but relapsed six months later. He again experienced hallucinations and thought insertion which he attributed to machines and telepathic forces.

He continues in employment but describes himself as changed, lacking interest in his appearance and being much less sociable. Again at two years he experienced positive symptoms on discontinuing his medication.

37 IJ 22 years Female Negress Trial Entrant

The patient and her three year old daughter lived with the extended family. Over days the patient became distressed and attempted on one occasion to jump from the window. On admission the patient remained mute for a week and then described herself as under the control of a force she experienced as a lump in her abdomen. She complained of thought insertion and felt the television was referring to her.

The patient made a rapid recovery and was maintained as an outpatient on oral Chlorpromazine for one year. At two years she is in her own flat and is charming, pleasant and insightful. She has advanced herself as a typist, is studying at night classes and cares for her child. There is no evidence of any defect.

38 DJ 31 years Male Caucasian Trial Entrant

This honours graduate had organised and obtained funds for a rehabilitation project for unemployed youths over two years ago. A year prior to admission he made three suicidal bids taking increasingly large aspirin overdoses. He left his work of his own volition and some months later was hospitalised.

Mental state examination revealed widespread delusions expressed in the presence of thought disorder, the patient describing positive energy used to achieve freedom for people, transmission of thought, an alternative universe and the fleeting belief that he could fly. He had many visual misperceptions and felt his head moved by alien forces. His mood was one of perplexity, his affect peaceful and distant.

His positive symptoms largely remitted, but he remained vague, and developed multiple mannerisms and later involuntary movements of his trunk when not taking neuroleptics. At two years he remains unemployed, but now has a common law wife and a child of the union.

His sister had some years ago died of herpes encephalitis during a course of electroconvulsive therapy. She had been diagnosed as suffering from simple schizophrenia.

39 VC 28 years Male Caucasian Eligible

This single Greek man in his final year of a MA course in Ancient History worked part-time as a teacher.

On admission he described himself as the victim of a well organised conspiracy. He believed his coffee had been drugged and

this had caused the loss of his voice, his post had been tampered with, and others were trying to frighten him for political reasons, and sent cars to follow him. He remained suspicious but pleasant.

Two months after this brief index admission the patient was readmitted but stayed only five days. He lapsed from contact and left the country to return to Greece two years after his first episode. He had not returned to teaching nor completed his studies.

40 AE 31 years Female Asian Trial Entrant

The patient was referred by the Maternity Services after the birth of her first child. On admission she described imperative hallucinations using her name, other illformed auditory hallucinations and distortion of time. She felt everyone was acting a part and both testing her and spying on her.

The patient responded rapidly and was discharged on oral medication. After one year she briefly experienced derealisation and some ideas of reference, but did not come to readmission. She has returned to secretarial work and has full time help with her child. At two years she remains well, and this is confirmed by patient and husband.

41 JO 22 years Male Caucasian Eligible

Having been brought up in various forms of institutional care and following Borstal training, the patient had spent the majority of his life in prison. He was referred by his probation officer.

The patient was grossly withdrawn, and described constant

severe auditory hallucinations, threatening to kill him. He experienced thought broadcasting, felt under the surveillance of the television and believed a conspiracy was at work.

He remained unpredictable and violent and made little progress. After one year's hospitalisation and many treatment measures, he was transferred to a special hospital under Section 65 of the Mental Health Act. He has never held employment and has no family contact.

44 MH 25 years Male Caucasian Trial Entrant

This well spoken youth was transferred under Section 60 of the Mental Health Act. He had one previous contact with psychiatric services aged eighteen, following parting from a girl friend. He had slept in the open and his only employment had been as a kitchen porter.

His spontaneous complaint of having only one pair of trousers was followed by descriptions of the spiritual transmission of alien thoughts and a secret religious organisation keeping watch upon him.

After six months hospitalisation, he was found a place in a local hostel. He remained withdrawn, lacking in volition but not overtly psychotic or depressed. Two years later the patient made an unorganised suicidal bid cutting his wrists. He was rehospitalised briefly. He remains deteriorated and has pill-rolling hand movements.

46 AT 20 years Female Caucasian Eligible

This daughter of an academic family had been investigated for her poor concentration and social isolation when aged eleven. She attended several schools but remained friendless and performing at a low academic standard. Whilst staying with friends in Great Britain she developed an increasing religious interest, and later became aggressive and assaulted her mother repeatedly over a period of about a year.

Initial hospitalisation for seven months was followed by two brief admissions and another of six months duration. She regularly described true auditory hallucinations of God and of a boyfriend in South Africa, felt she knew the future, and was childlike and suspicious.

Three years following the index admission the patient remains at home, many forms of hostel accommodation having failed. She attends a private psychotherapist and has limited psychiatric contact, and remains unpredictable, explosive and childlike.

47 DS 18 years Female Caucasian Eligible

Admission was arranged by the parents of DS, both parents being trained psychiatric nurses. They had recognised their daughter to be shy and academically limited, and had encouraged her interest in art.

At admission DS was withdrawn and nearly mute for some weeks, and later displayed an empty fractured affect, making reference to being followed by people from famous art colleges and having a

special relationship with the deity.

DS made a very slow remission, but did not gain full insight. Day hospital attendance was discontinued for a holiday in Ireland after a few months.

At two years DS remains extremely limited. Her only outside interest is attendance at an art class. Minor events produce a recurrence of positive psychotic symptoms, and these episodes are managed on an outpatient basis.

48 GG 24 years Male Caucasian Trial Entrant

The patient was a trainee in hotel management, having previously completed a university degree, studying comparative religion. His letters home were bizarre for a few weeks, and at home on holiday he became acutely restless. He came to admission via the police.

Mental state examination revealed a complex religious delusional system involving a special mission and possession by both God and the devil. He believed he was protected by an archangel as his middle name was Michael, and also had visual and auditory hallucinations. He believed other patients had access to his private thoughts.

Soon after discharge the patient refused medication, and went to Ireland to teach in a private school. He became briefly psychotic ten months after discharge. He restarted neuroleptics for only a few weeks. In the subsequent eighteen months he has completed a diploma in teaching and is entirely well. He is due to go abroad to teach.

In this time his mother has developed a paranoid psychosis and been admitted under Section 29 of the Mental Health Act.

49 AAG 24 years Male Negro Trial Entrant

The patient was admitted under Section 25 of the Mental Health Act after assaulting his wife. His wife had had two brief admissions under Section 136 to the same hospital in the past.

Mental state examination revealed a mass of tactile, olfactory and auditory hallucinations that the patient attributed to voodoo perpetrated by his wife's family. He felt they wished him to become a Rastafarian. They took control of him and described inexplicable connections and messages involving cats, dogs and articles of clothing.

Follow up was complicated by the patient's re-housing, but he remained well for some months on oral drugs. The marital situation he reported as deteriorating and nine months after discharge he killed his wife by repeated stabbings, and immediately went to the police.

He remains in care, detained under Section 65 of the Mental Health Act, but is entirely well on depot neuroleptics.

50 MN 31 years Male Caucasian Eligible

(Insulin dependent diabetic)

The patient had worked for some years as a self employed model maker, but had led a limited social life, and lived at home with his parents. He suddenly resigned and repeatedly visited the police complaining his car was bugged and others wished him harm. He was hospitalised for four months, his management complicated by his diabetes. On admission he was hallucinated, grossly paranoid and terrified. On discharge he found himself unable to continue his past employment. After one year he discontinued his neuroleptics and at two years gained employment as an occupational therapist's assistant. Shortly after this he began to experience positive symptoms once more.

51 PJ 43 years Male Caucasian Trial Entrant

The patient lived with his elderly mother and had regular contacts with his siblings living locally. He had attended a school for the educationally subnormal and was recognised by his family as limited. For many years he worked as a warehouseman but for three years had personally deteriorated and given up work. He began to talk of having a wife and family from a previous existence in Scotland and on one occasion walked, hoping to reach Scotland, but reaching 200 miles from his home. Admission via social services resulted in prolonged inpatient care, and a limited impression was made upon his psychosis. He has been maintained in a day centre for the last two years. His psychotic ideas remain readily accessible.

52 IR 25 years Male Caucasian Trial Entrant

The patient had a long history of unusual behaviour, wearing flannel around his head to keep his brains in. Having worked steadily for three years he gave up work. His mental state deteriorated over a year and he was compulsorily admitted personally deteriorated and thought disordered. He conveyed fragmented ideas of lions and scorpions tormenting him and was in communcation with Christ via his conscience by powers of voodoo. He believed Christ wished him to strangle himself and that he would stand trial for treason.

The patient's mother had repeatedly been admitted compulsorily and treated for chronic schizophrenia. His father had in the past received ECT, and his maternal grandmother had died in a mental hospital.

The patient was discharged with no apparent psychotic ideas and immediately evaded any contact. He has been lost to follow up.

53 JS 22 years Male Caucasian Trial Entrant

The patient had always been noted as different from his siblings, having performed poorly academically and given to visual fantasy. He attended horticultural college but failed to achieve a diploma. Later he worked as a porter in a well known antique dealers.

He became more withdrawn over a few weeks and came to believe people were putting their tongues out at him on the trains. He went

missing and was eventually admitted. He had fragmentary auditory hallucinations, could hear Christ and an ex boyfriend talking and experienced thought reading. He believed he had been to distant worlds in a spaceship and had bizarre misperceptions of people having stick-on eyes over their real eyes.

Following discharge he had repeated brief admissions and at two years has entered an after care hostel. He works briefly in casual jobs, and is vulnerable to homosexual contacts.

56 CS 24 years Male Negro Trial Entrant

This constitutionally large negro lived in lodgings and worked as a security guard. He had had limited schooling and was socially isolated. He became immobile at work, and expressed in a perplexed way auditory hallucinations of his distant family and misidentified people as his mother. During admission he acquired the nickname Gentle Giant and was placid and dependent. He remitted, returned to work and tried to extend his contacts by doing voluntary work. 28 months later he relapsed and was found wandering, perplexed and disorganised.

57 GVA 17 years Male Negro Trial Entrant

This youth was a trainee lithographer and attending a day release course. He became psychotic abruptly and complained of auditory hallucinations both imperative, abusive and occasionally complimentary. He had a mass of hallucinations in all modalities and later told us how the bath seemed to be full of blood. His

grossly disinhibited and disorganised behaviour was not manageable in an open mixed ward. After protracted care he made a fair recovery and later discontinued his depot medication.

He experienced a sudden serious relapse when he had started college once more.

His brother, paternal aunt, and maternal aunt all have had schizophrenic illnesses.

58 DB 23 years Male Caucasian Eligible

This well educated youth was studying for a postgraduate music degree and living in a student hostel. He was a talented classical guitarist. He was admitted and expressed a widespread delusionsal network involving a communist plot, revolutions, and heard a girl from Barcelona calling him to come to her. He was grossly thought disordered and distant. He later absconded and then was repatriated and contact was lost.

59 MH 19 years Male Caucasian Eligible

One of a sibship of three, MH was a clumsy awkward youth and extremely academically limited, in constrast to his two sisters. A brief episode when MH expressed fears of others and was afraid others wished to poison him settled with no medical contact. One year later MH became very withdrawn and somewhat suspicious, and played his drums all night. He expressed fears that others would kill him, and came to hospitalisation.

MH had received education at a variety of schools in an effort

to meet his special needs. The father of the patient had left home some years previously, at that time convinced that a conspiracy involving the British Broadcasting Corporation was at work to persecute him. The mother of the patient, an art and drama teacher, had made no connection between her son's illness and the breakdown of her marriage.

Very prolonged day care continued for almost 18 months. MH in the later months held a simple part time post selling programmes in a theatre. He remains maintained on medication.

60 AJ 54 years Female Caucasian Organic

61 JP 26 years Female Caucasian Trial Entrant

This young administrator was admitted from hospital accommodation in apophanous mood (Fish. F. 1976), perplexed and disorganised. She expressed multiple misperceptions, delusions of thought interference and fragmentary hallucinations combined with partially held religious delusions. She made a rapid recovery but had difficulties on returning to work. Leaving her employment she returned home and quickly discontinued medication. She remained well over the coming two years, married, and was fully employed in an administrative capacity at another hospital.

62 JO'S 20 years Male Caucasian Eligible

The patient's parents had been concerned over their son's

isolated and moody behaviour for some months. Admission under Section 25 was achieved. The patient was highly suspicious but eventually revealed a well organised delusional network. He believed whole cities and all they contained had been set up and altered to alarm him and had travelled to cities in the north west to confirm this idea. This was in some way connected with a brilliant political future for him. Progress in hospital was slow and insight far from certain. He was discharged some months later and returned to work. At 24 months he relapsed and was readmitted.

64 M 42 years Female Caucasian Unconfirmed by PSE

This divorced lady was admitted having expressed ideas concerning tape recorders, bugging and surveillance at home. When in hospital she was hostile to interview and refused to account for this. She had led a bizarre life, changed her name by deed poll and been long interested in the occult, illicit drugs and paranormal phenomena. Despite her hostility she attended a day centre following discharge and took oral medication. At 24 months she continues to attend the centre, and has undertaken some voluntary work. The patient has been off medication for five months and is well, following two previous unsuccessful attempts to stop the neuroleptics.

65 LG 32 years Female Caucasian Trial Entrant

The patient was living at home with her widowed father. Some years previously the patient had married and led a chaotic life,

losing touch with her family. Having once worked in a secretarial capacity the patient kept to her room and became increasingly hostile towards her father. She lost weight, refusing food, and became grossly deteriorated, unable to cope with menstruation. On admission she expressed the idea that her father was the devil and that she had a special religious purpose. She was hallucinated, withdrawn and bizarre. Following a slow remission, the patient lived in a hostel and spent three months on holiday in Canada with her father. Later she relapsed but responded quickly to reintroduction of neuroleptics. At eighteen months, living alone in a flat, the patient reverted to the behaviour that caused her initial hospitalisation, but again responded to some degree to neuroleptics. She remains at home with her father, unemployed, and under psychiatric supervision.

A cousin of the patient is similarly affected.

66 DW 42 years Male Caucasian Eligible

The patient lived alone but worked in an unskilled capacity with his brother. On admission he was agitated and expressed the fear that he would be killed and the belief that a machine was affecting his mind and his back. The initial conviction that he was the subject of a brainwashing experiment faded, but he described perceptual heightening, loss of emotion and the slowing of time. Following discharge his medication was discontinued. At two years he remains entirely well and fully employed and his family report him as being normal.

67 MS 24 years Female Caucasian Trial Entrant

This clerical supervisor had lost her job eighteen months previously and been clearly unwell for six months. She was admitted perplexed, nearly mute, and hesitant. She expressed delusions of thought broadcasting and auditory hallucinations saying "she's stupid" and misperceptions of taste, touch and vision. She believed others were hypnotising her using electrical fields.

After four months she was discharged but did not gain employment and took a large overdose six months later. She remains at two years, fairly well socially preserved but unemployed and often having psychotic experiences.

The patient's mother has been treated for epilepsy and has had psychotic features at times.

68 FS 21 years Male Mixed Asian/French Trial Entrant

This socially disorganised youth with a history of police contacts worked as a relief man in the local car factory. He took five weeks off work and was slow and underactive. He experienced auditory hallucinations of the girl next door commenting on his thoughts and actions, and visual misperceptions. He was moderately unco-operative with treatment but remitted, and attended follow up sporadically. He was briefly readmitted seven months later but took his own discharge and was lost to follow up.

69 GD 57 years Female Caucasian Trial Entrant

This well preserved divorcee had an eight year history of psychotic experiences mostly of a sexual nature. These remitted with neuroleptic medication but the patient complained of side effects. On small doses of neuroleptics the patient developed a gross movement disorder of the lower limbs after nine months drug treatment, and began to lose weight. Eventually the drugs were discontinued, with a rapid return of psychotic features. She is working as a paid companion and attends day care once a week. There is a history of alcohol abuse in her brothers, and one brother has developed some kind of movement disorder in late life.

71 AM 34 years Male Caucasian Trial Entrant

The patient fractured his heels after jumping from the second storey of a car park. He believed that the street signs had special significance for him and he jumped under the belief that this was a test from God. He gained partial insight during his admission and returned to his occupation of bricklayer after discharge. His wife encouraged him to persist with oral medication and at two years he remained well. There is a strong family history of alcoholism.

72 BD 41 years Female Caucasian Trial Entrant

The patient, a spinster, lived at home with her father and sister. Contact had been lost with the brother who left home aged 26 and never returned. The patient worked as a secretary and coped

well. On admission following a few weeks ill health, she complaiend of auditory hallucinations, believed her mind to be "bugged" via her hair clip and feared people had entered the house and poisoned the sugar. Despite the brief onset she was very deteriorated. She responded to oral neurleptics and returned to home and work, and coped well with her father's ill health and subsequent death. A brief relapse nine months later remitted quickly. At two years the patient remains well and socially intact.

73 RB 27 years Male Caucasian Trial Entrant

The patient lived with his parents who were both schoolteachers, in a comfortable home. He had attended many special educational establishments and was recognised as different from his elder married brother. Whilst studying at agricultural college concern about his mental state had been conveyed to his family some years before his presentation. After an episode of violence and destruction, he was admitted and expressed complex thought disordered ideas of a pseudophilosophical nature and felt himself under the influence of "mental atmospheric" forces. At this time he decorated the garden with many ornaments from the home and destroyed his own room.

He has relapsed twice in the two year follow up and is maintained on depot neuroleptics. He is unemployed, attends a day centre occasionally and always expressed odd ideas of supernatural and psychic forces at work around him.

75 MK 24 years Female Asian Trial Entrant

This young Asian woman, one of a large sibship, lived a socially disorganised life. She was admitted with an eighteen month history of deterioration and was constantly auditorily hallucinated. Her florid schizophrenic illness included many sexual delusions and hallucinations with suicidal ideation in response in part to imperative hallucinations. She had previously consulted spiritual healers.

Follow up was complicated by the patient repeatedly moving from sibling to sibling. She married a year later and became psychotic in the second trimester of her pregnancy and restarted neuroleptics. Postpartum she remained hallucinated but had insight and was supported by community psychiatric care.

The patient's mother had been under psychiatric care.

76 HR 40 years Male Caucasian Trial Entrant

This continental worker had come to England sixteen months prior to his admission, following a bankruptcy in Germany. Shortly after arriving he attempted to kill himself with car fumes but took his discharge from hospital without treatment. Subsequently admission was organised by his employer. The patient described himself as being persecuted by an ex colleague and had believed his room to be bugged with a microphone. The radio referred to him in code and he experienced perceptual abnormalities in the mirror. Some three months after discharge contact was lost, but later a police enquiry revealed he had had difficulties once more. He was

repatriated.

77 PB 24 years Female Caucasian Trial Entrant

This attractive girl, looking younger than her 24 years, was admitted believing that the whole neighbourhood was gossiping about her romances. She expressed a mass of sexual delusions and was very distressed.

Her sister was under treatment for anorexia nervosa and her mother recently diagnosed as suffering from carcinoma of the uterus. She made extremely slow progress, her hospitalisation lasting over one year. After discharge she rapidly experienced hallucinations once more and was readmitted and transferred to a hostel. The patient was previously employed as a telephonist. At two years she remains moderately unwell, takes depot medication, and has briefly held part-time work in a cafeteria.

78 MD 37 years Female Caucasian Trial Entrant

This unmarried mother lived in council accommodation with her 10 year old son. She was admitted mute and perplexed but within days had an apparently normal mental state. She described her delusions involving the IRA as fleeting. However six months later she relapsed and was briefly readmitted. A year subsequently the patient had a further brief admission and has since had psychotic features but these have been treated on an outpatient basis. She remains unemployed and is slightly deteriorated. A sister in Ireland has a diagnosis of schizophrenia.

79 KW 17 years Female Caucasian Eligible

This young girl was described as a mature sensible cheerful girl in her school leaving report. She worked in a warehouse but lost this job one month prior to admission. She described a conspiracy to force her to lose the job and feared others were poisoning her, and believed that God caused her face and head to move against her will. Prior to admission she refused food, threw away her clothes in the dustbin and ran down the road screaming. The patient remained in full or partial hospital care for most of the first year following her index admission, and remains unemployed and on depot medication.

There is an extensive family history of psychotic illness on her father's side and the patient's maternal aunt had a puerperal depressive illness.

81 SR 35 years Male Caucasian Trial Entrant

Despite having once obtained a place at university, the patient had a very poor work record and was of no fixed abode. He had a ten year history of minor criminality, largely shoplifting. On admission he expressed poorly held delusions at great length in a monotonous tone. He believed amongst many delusions that radio programmes were organised by the psychologists, uncannily reflecting his thoughts and experience. He made slow progress and was rehoused in a flat after spending six months in hostel care. Contrary to expectation, he remained well and co-operative although unemployed,

but relapsed into mute disorganised psychosis twenty eight months after his index admission.

82 KA 27 years Female Negro Eligible

This Nigerian woman came to England four years previously to obtain secretarial qualifications and worked in this capacity until one month prior to admission. She left feeling others were calling her 'mad' and came to admission after the police found her wandering the streets in her night attire. On admission the patient was bewildered and afraid and complained of threatening auditory hallucinations. She believed she was a prophet.

She improved gradually and later sporadically attended day care. Contact was lost after she began some domestic work but one year later she returned to the unit briefly, feeling herself to be in danger. She left the hospital immediately and could not be found.

83 MO 23 years Mixed Race Trial Entrant

The patient returned to Great Britain after completing his schooling in Nigeria. He had a four year history of unusual behaviour, had been repeatedly returned to Britain from foreign embassies, and had outbursts of uncontrolled violence.

On interview he was bemused and perplexed, describing auditory hallucinations of music from America, brain waves allowing him to thought read and thought broadcast, and believed that the food he smelt today was the smell of the food he would eat the next day.

He made fair progress in a hostel, but changed from depot to oral medication when he was rehoused in a flat. He promptly relapsed. He has since relapsed again, and remains unemployed.

His father probably suffered from Othello's syndrome and his maternal aunt has a history of psychotic depression.

84 DK 27 years Male Caucasian Trial Entrant

This Greek youth was apprehended climbing the wall of a Royal residence. He believed himself to be in telepathic communication with a member of the Royal family and had auditory hallucinations of Christ. He had been violent at home and bit his brother's arm to the bone.

Within two months of discharge he was readmitted from a local bridge, having intended to jump in response to imperative hallucinations. His face was disfigured with cigarette burns, done in response to the imperative hallucinations. He remains chronically unwell.

85 RH 28 years Female Caucasian Trial Entrant

This married professional musician functioned at a high social and intellectual level. She became unwell over a few days and was floridly psychotic. The patient misidentified those around her, heard her father's voice from America and laughter, and believed the television had turned into a computer. She believed she must have been dead for some time as she felt she no longer had a shadow.

The patient eventually remitted and became entirely well. She

has continued to advance her career, remains socially charming and is entirely normal at two years.

The patient's mother has a very long history of serious affective illness.

87 DR 20 years Female Caucasian Trial Entrant

The patient was admitted three weeks postpartum having developed psychotic symptoms ten days after delivery. She presented as a disorganised disinhibited young woman expressing delusions that she was the Virgin Mary and able to broadcast her thoughts to her sister in Nottingham. On one occasion she attempted to jump out of the window. Her disinhibition exacerbated the marital strife and the patient was slow to improve. In the absence of positive psychotic symptoms, DR was mildly flat in affect and lacking in volition. At two years she remains free from psychosis and at home. She copes with her child much assisted by full time nursery care, support from her spouse's family and the health visitor.

88 MD 21 years Male Caucasian Trial Entrant

This semiskilled worker lived at home and was an enthusiastic participant in the Territorial Army, having obtained the best cadet award some four years previously. He developed a complex delusional network based on auditory hallucinations of an officer and became fearful for his life. Following partial remission a degree of affective flattening was apparent. He returned to work, and some months later was apprehended for exposing himself in a public park.

He remained free of psychotic symptoms until his medication was discontinued after two years, when he took an overdose in response to voices once more. He made a prompt recovery from the relapse.

92 SR 18 years Male Caucasian Trial Entrant

This strikingly odd youth had always been different from his siblings. On admission he was evasive, hostile and sullen but described his breathing as being controlled by others who were against him. He was reluctant to co-operate and remained unemployed. His mother described him as totally affectionless from infancy.

One year later his sexual behaviour in relation to his younger sisters caused concern and the patient was readmitted.

The patient's maternal uncle had had a schizophrenic episode treated locally.

95 VF 56 years Female Caucasian Eligible

This married lady had been bizarre for some ten years and came to admission under Section 60 of the Mental Health Act following non payment of many bills. The patient believed that she had been sent inflated bills due to conspiracy of show business people and complained bitterly of the magnetic pick-up device connected with the television. She described believing for many years that newspapers and television referred to her and mimicked her. The patient's home was covered in posters and displays concerning this theme.

A modest improvement was followed by outpatient care. The patient continued to be subject to Section 60 of the Mental Health Act.

96 JS 37 years Male Caucasian Eligible

An unemployed painter and decorator of Irish extraction was referred by his general practitioner. He was found to be suffering from a florid paranoid psychosis, but promptly absconded to Ireland.

97 BP 40 years Male Asian Trial Entrant

The patient's son gave the history of fourteen months of disturbed behaviour following upon the patient losing his job. He had assaulted his wife and daughter and described in poor English auditory hallucinations of female voices swearing and of President Carter, and had widespread somatic delusions of bodily change.

Despite energetic treatment with neuroleptics the patient was maintained outside hospital for only two months after discharge following six months treatment. At two years the patient has many positive and negative schizophrenic features and is attending day care.

Another child of the patient has been under psychiatric care for what may be a manic illness.

98 NH 47 years Male Caucasian Trial Entrant

This odd little man lived with his spry elderly mother and worked unskilled in a factory. Contact with two siblings had long

since been lost and the patient's father had died in a mental institution.

The patient became withdrawn over about four months and began to express the idea that the television was interfered with, that the Queen smiled specifically at him, and that he was to become a brain surgeon. He came to hospital, still expressing his reluctance to operate.

He has remained outside hospital, in full employment taking depot medication for two years, but his presentation remains deferential and his appearance in keeping with a chronically psychotic patient.

100 OC years Male Negro Unconfirmed diagnosis on PSE

This limited youth was overactive and elated on admission. He expressed his belief in his unusual powers, largely connected with those in familiar strip cartoons. The PSE rated him within the manic category.

102 SK 37 Years Male Caucasian Trial Entrant

The patient was a lecturer at a polytechnic in arts. He became suddenly psychotic, and his hallucinations told him to co-operate. Admission to the local mental hospital was followed by rapid recovery. Although the hallucinations stopped the patient did not gain full insight.

Over the next two years the patient achieved promotion to a full-time post and continued to attend as an outpatient.

104 RG 22 years Male Caucasian Trial Entrant

The patient lived at home with his parents and two younger brothers. He was admitted after three months of expressing delusional memories of violence and described thought echo and was convinced he was subject to telepathic forces. He had been verbally hostile towards his mother and on one occasions smashed a rifle to pieces on a concrete path.

At two years he is outside hospital in full-time employment. However he remains shy, isolated and occasionally preoccupied with paranormal themes. His co-operation with oral medication is heavily encouraged by his parents.

105 JM 32 years Male Caucasian Trial Entrant

The patient worked for the local authority as a foreman plumber, and lived in a well cared for home with his wife and three children. He developed over a few weeks a well organised paranoid psychosis involving conspiracy at work. It was only when he expressed delusions of reference concerning the television and radio that his wife sought psychiatric aid.

He was treated with intramuscular depot injections of neuroleptics and made steady progress. At two years he remains at home and is now self-employed. He clings to his paranoid ideas to some extent but functions socially at a reduced level. He has

marked piano playing movements of his fingers. His brother had committed suicide some years ago.

106 EB 39 years Female Caucasian Trial Entrant

This partially deaf lady worked in a paint factory and lived with her husband in a bare house decked with labels. There were no children of the union. The patient was a trained nurse and her eldest sister worked in the medical field.

The patient's husband had noted a change some three years previously and presented copious notes and a tape-recording to the medical staff when EB was admitted. The patient herself described incessant auditory hallucinations calling her "human failure" and a paranoid network involving unknown religious forces and persecution by the BBC.

The patient was withdrawn from the drug trial after two months by the general practitioner, but has stayed out of hospital for two years and continues to work.

107 AW 26 years Male Caucasian Eligible

The patient, an honours graduate, had secluded himself in his room for months. He was compulsorily admitted from the roof of his home, clad in ladies underwear. His behaviour remained bizarre, kissing dustbins and wandering, unable to convey his ideas. After a three month admission he made a full recovery. He remains socially normal with a degree of sophistication and charm and works in a capacity suited to his intellect. The patient is maintained on

small doses of neuroleptics.

108 PE 20 years Female Caucasian Trial Entrant

The patient had moved to a small town distant from London seeking cheaper accommodation for her eighteen month old child. Her husband commuted to the city daily. The onset of the illness was hard to define but the patient became very disturbed over a week, and was up at night telephoning the police. She believed that her neighbours were conspiring against her and became so afraid of letters that she ate the circulars and advertisements delivered by post. On enquiry the patient expressed religious delusions concerning the devil and described thought insertion.

After a three month admission the patient achieved limited function, having moved house to very near her parental home. She relapsed nineteen months later following a termination of pregnancy. Although her positive symptoms remitted the patient cannot achieve even limited social function, despite strenuous efforts at rehabilitation. Referral to long term inpatient rehabilitation is under way.

109 EC 21 years Male Caucasian Eligible

One of four sons of a seagoing engineer, the patient had an unexceptional childhood and adolescence. He was admitted with a two month history and was clearly in apophanous mood. He described telepathic communication, visual misperceptions and widespread ideas of reference. His illness continued to develop in the face of high

doses of neuroleptics, with true auditory hallucinations occurring. The initial six month admission was quickly followed by a three month one. At two years the patient has persistent positive schizophrenic features, and remains unemployed at home.

110 NT 29 years Male Caucasian Trial Entrant

This divorced man had custody of his six year old son. He had been unemployed for years, and had fleetingly been unsuccessfully self employed.

In this setting of some social chaos the patient developed a paranoid illness believing himself to be involved in a national investigation of police corruption. He believed the telephone was tapped, the house bugged and that cars followed him. The patient was admitted, but refused follow up after his discharge a month later. When drug free he described loss of emotion and drive that greatly distressed him.

He has briefly had contact with his family practitioner and by his family's account the social chaos has become severe. At two years the patient's mother was attempting to gain custody of her grandchild, who had been abruptly deposited in a private boarding school by the patient in unusual circumstances.

111 MD 44 years Female Caucasian Trial Entrant

This married woman was admitted grossly psychotic. She believed the Jehovah's Witnesses were squatting in her house and attributed hallucinations to them. Much of her conversation was

difficult to follow:

"If somebody else looked in the mirror, somebody even from Ramsgate, I could see that the cushions of the chair would move and I could hear what they were saying. She would be talking about her life, talking to me, saying 'she and her husband are crippled'".

The patient was married to a man seventeen years her senior. The three children of the union had problems, one attending a special school, one attending a child psychologist.

At two years the patient is entirely well, pleasant, and more organised in coping with her significant social problems. The patient participated in the trial and was maintained on placebo for those two years.

112 RJ 19 years Male Negro Trial Entrant

The eldest child of a sibship of three the patient lived in his comfortable West Indian family home.

He became abruptly disturbed, ran away, and was found a week later in a hostel by his father. On hospitalisation the patient revealed that he knew he was going to die and described the Devil taking possession of him. He had experienced auditory hallucinations of thunderclaps, the wrath of God and later His favours were expressed in a mass of ideas of reference and of visual misperceptions.

The patient made good progress on oral neuroleptics, and his confidence increased. He returned to work but relapsed after nearly two years on ceasing the medication of his own volition. He described when well how he had experienced paranoid delusions for

twelve months prior to the acutely disturbed behaviour.

113 AH 39 years Male Caucasian Unconfirmed diagnosis on PSE

This married maintenance engineer had a four month history of loss of well being. He described definite ideas of reference concerning the doubts of others over his financial honesty and sexual normality in a setting of pressure of thought. The PSE placed him within the manic category.

114 SW 18 years Male Caucasian Trial Entrant

This limited youth had always been nervous and had attended child guidance. He was admitted with a two month history of illness and freely expressed a mass of sexual delusions, and was convinced that the hospital ward was a somewhat inefficient brothel. He described people at work as having direct access to this thoughts.

He made steady progress and was discharged to a day centre for rehabilitation. He remains rather awkward but more sociable and has begun industrial retraining, and is well at two years.

His brother is a severe psychopath and his mother is constantly supportive to him and his promiscuous sister.

115 PM 29 years Male Caucasian Trial Entrant

When unwell the patient travelled from his farming community in Ireland to Great Britain and was admitted from his sister's home. He believed his voice to be under the control of others and had a

complex religious delusional network, hearing the voice of Christ. He made a fair recovery and worked unskilled. Despite some personal wealth he remained untidy and dishevelled. Eventually he returned to Ireland but relapsed within the year.

His sister has had a schizoaffective episode from which she made an excellent recovery. Recently a more extensive family history has been revealed.

116 CA 20 years Male Negro Eligible

The patient was the son of a chronically disturbed and hospitalised lady. He presented with a one week history of distress when he had made two attempts to kill himself. He believed that his brain was frying, smelt his body rotting, and described forces making him walk faster and slower. He felt another alien intelligence was affecting him and saw his face as changing from younger to older.

His index admission lasted over a year and he was discharged to a supportive hostel and full-time day care.

117 HS 33 years Male Asian Previous Episodes

The patient had many previous episodes of schizophrenia treated elsewhere.

118 LK 44 years Female Negro Eligible

The patient took her own discharge after three days. Having

once been a state registered nurse she was of no fixed abode and was vague, hostile and dishevelled.

119 RM 23 years Male Caucasian Unconfirmed diagnosis on PSE

The patient had longstanding drug and alcohol related problems. He presented with neurotic depression in the setting of an abnormal personality.

120 SB 36 years Female Caucasian Trial Entrant

The patient lived with her father. She was well recognised by the family as a lesbian but maintained close social contact with her married sister. For many years she had been slightly odd.

She suddenly developed a grossly disorganised psychosis. During a few days she threw away eighty pounds, put all her shoes in the dustbin, attempted to get into bed with her brother-in-law, shouted obscenities at a bus stop and talked and laughed to herself. Eventually admission was achieved. The patient continued to experience auditory, tactile and olfactory hallucinations and thought insertion perpetrated by green robots.

After a slow recovery the patient returned to home and to work. Relapse occurred a year later when the patient was on holiday in a foreign setting.

121 AH 21 years Female Caucasian Trial Entrant

This separated mother lived with her three year old son nearby

her parental home. Over one month she became afraid, repeatedly misidentifying people as her estranged spouse, and on more than one occasion ran off. She came to admission floridly psychotic, her delusions based on her fear of her spouse.

She made a good response but later had several grand mal fits. At two years she is entirely well and seeking work. There is no family history, and no past history of epilepsy. However the patient continues to experience legal problems over the separation from her psychopathic spouse.

122 IL 21 years Male Asian Trial Entrant

The patient came to Great Britain eight years prior to his illness. He became mute and withdrawn and refused food. On admission he was emaciated with gross ankle oedema and stood motionless for hours.

His behaviour became more normal but he consistently refused to discuss his mental content for religious reasons.

A few months after discharge he failed follow up and contact was lost.

123 NS 40 years Male Asian Trial Entrant

This married man in poor physical health was brought from London to Luton by his children, to enlist the aid of an uncle. His complaints on admission centred on the use of a flash gun by an agency, the television watching him, and hypochondriacal themes.

He returned to north west London leaving many confusing

contacts with social services in his wake.

The patient's wife joined him subsequently but contact was lost when the family moved house.

124 CK 54 years Female Caucasian Trial Entrant

A trained nurse, this divorced lady had a long history of vague ill health, and worked in a domestic capacity in the NHS. Her only daughter suffers from epilepsy and they maintain very limited contact. On admission CK described persecution by her neighbours, believed machines to pick up her thoughts and spread them, and complained of illformed auditory hallucinatory experiences. The patient made a limited recovery, but was affectively flattened. Three months after discharge the patient lost her employment and came to a further admission which lasted six months.

125 TB 59 years Male Caucasian Trial Entrant

The patient lived alone having separated from his wife eighteen years previously. One son kept close contact and noted his father's somewhat squalid home circumstances to worsen over a few months. The patient became briefly disturbed and admission was effected. He complained that an organisation had arranged a chemical spray into his eye, ostensibly from a passing car, and he described time distortions, illformed auditory hallucinations and ideas of reference.

After a brief admission the patient rapidly relapsed never to entirely recover, and longterm care was arranged.

126 AM 34 years Male Caucasian Unconfirmed diagnosis on PSE

This somewhat inarticulate labourer lived with his wife and two children. On admission he was grossly anxious with widespread delusions where others accused him of homosexuality. This conspiracy seemed to the patient to stem from work.

The patient remitted quickly but relapsed within the year. His marriage has broken down and he is currently unemployed.

127 VS 18 years Female Caucasian Trial Entrant

This plump pretty girl described everyone as against her, believed others to follow her on the underground, talking about her. She experienced tactile hallucinations and believed she had special telepathic powers concerned with thought broadcasting.

The patient's mother, a divorced Italian speaking lady described VS as having assaulted her, and also described the longstanding difficulties with her seriously psychopathic son.

Following a four month admission VS remained out of hospital for eight months, but could not gain employment, despite having worked before. Her second admission has lasted for over a year.

128 ILW 21 years Male Negro Eligible

This youth was admitted under Section 60 of the Mental Health Act. He complained of auditory hallucinations swearing abusively at him, and at times giving him orders. He had unusual somatic and

visual hallucinations of people entering his body.

The patient's father had committed suicide and the patient's brother was currently an inpatient in a special psychiatric hospital.

After a three month admission ILW was discharged to a hostel, to attend a day centre organised by the probation services.

129 BL 18 years Female Negro Unconfirmed diagnosis on PSE

This restless overactive girl believed she had the power to be God. The PSE placed her within the manic category.

130 RG 27 years Female Caucasian Eligible

This married woman was admitted in distress expressing a mass of bizarre sexual delusions. For some days prior to admission the patient had been screaming and violent. She described auditory hallucinations and nuclear features of schizophrenia. During her admission she repeatedly removed her clothes, and had to be briefly secluded when screaming.

After a sexual incident on the ward, the patient went on leave and transferred her care. At two years she is reported to be well and working after a long illness.

The patient's husband had been under private psychiatric care prior to this, and his mother had died when an inpatient in psychiatric care.

131 RB 19 years Male Caucasian Trial Entrant

The patient's mother had been increasingly concerned for her son over a six month period. He was charged by the police, but released home from a remand centre. Admission to the local mental hospital was effected.

The patient described wizards reading his mind, the presence of a third eye in his forehead and was embroiled in pseudophilosophical themes. After a stormy admission the patient remained in moderate health outside hospital for three months. He was readmitted, and eventually died of an overdose of Diconal when on leave, thirteen months after his index admission.

The patient's brother is very unkempt and asocial, but there is no other known family history.

132 KD 36 years Male Caucasian Eligible

This unemployed man lived with his retired father and his mother, who worked as a domestic help. Sixteen years previously the patient had been admitted for 24 hours, but had refused all other intervention. Ever since that early onset the patient had remained hostile, aggressive and strange. He came to admission having taken an overdose in response to delusions of possession concerning a demon. He had many delusions including thought reading.

The index admission of four months was quickly followed by another of three months. Within the year the patient took his own life in a deliberate and well organised fashion.

133 BM 32 years Male Caucasian Trial Entrant

This married bricklayer was on holiday abroad with his family. He suddenly developed an acute psychosis, and was flordly disturbed. He ran from the camp site with a child in his arms, screaming for help. En route for home, he barricaded the hotel room, and talked freely of machines, bugging, plots and described auditory hallucinations of Scotsmen plotting aginst him. He leapt from the train on arrival and ran off.

Admission was organised by the police. He rapidly developed good insight. Within a few weeks of discharge he stopped all medication.

At two years he remains well, in work, and his longstanding marital disharmony persists. He lacks volition to a mild degree and resents this.

134 AP Unknown Female Precipitous Discharge

The patient took her discharge after 48 hours, but had received treatment elsewhere in the past.

135 RM 40 years Female Caucasian Eligible

This widowed lady believed herself to have been affected by an "illegal drug" given to her four years previously after a termination of pregnancy. She revealed a circumscribed paranoid psychosis at interview and described herself as saving lives via the citizens advice bureau by reporting such drug distribution.

The patient's three adolescent children had organised the admission aided by a distant relative.

137 PT Unknown Male Caucasian Eligible

On admission the patient expressed ideas of reference concerning other's views of his marital faithfulness, and had clearly interpreted ordinary notices as special messages encouraging him to telephone his family.

The patient took his discharge at ten days.

138 SW 31 years Female Caucasian Trial Entrant

This ill-educated woman lived with her parents and had care of her illegitimate three year old son. She had been married many years previously but this relationship had lasted only months.

In the setting of longstanding phobic anxiety the patient developed ideas of telepathic and paranormal forces at work. She sought the assistance of many religious organisations, but came to admission. At this time SW described hallucinations in many sensory modalities, in particular voices saying "You are stupid, you've done it all wrong, jump under that car".

The patient would only accept day care. A minor relapse five months after discharge was treated on an outpatient basis. Heavily supported by psychiatric community services the patient remains out of hospital and functioning at a limited level at twenty months.

139 EA 20 years Female Mixed Eligible

This child of a Nigerian father and a German mother had been brought up in a children's home from the age of eighteen months. Gross behavioural problems required inpatient treatment in an adolescent unit. However having worked for one year in a secretarial capacity in a solicitors' office the patient became psychotic. She cut off all her hair, believed others intended to kill her, and was convinced the television and radio referred to her.

The patient remitted and was discharged to a hostel. A few weeks later she left the hostel suddenly and contact was lost.

140 CM 20 years Female Caucasian Unconfirmed diagnosis on PSE

This au pair was admitted distressed, having toured London in a taxi. The PSE placed her within the Depressive category. Hospitalisation was prolonged.

141 IB 20 years Male Caucasian Unconfirmed diagnosis on PSE

The PSE placed the patient in the neurotic category. He had many obsessional symptoms.

142 TB 46 years Male Caucasian Unconfirmed diagnosis on PSE

Admitted following a suicidal bid, TB suffered an illness characterised by hallucinations and delusions of guilt.

143 CL 30 years Male Caucasian Eligible

This dishevelled man was of no fixed abode. He expressed delusions concerning the police, connected with his descent from the Stuart line and a mass of thought disorder: "Everything is constant in your mind. The lack of constant awareness of noise comes from various dimensions but they are constant. Noises like mediocrity".

The patient mentioned other hospitals, but no trace was found of any past contact.. He took his discharge in a few days.

144 DH 23 years Male Caucasian Trial Entrant

On admission the patient admitted to hearing the voice of a girl, but thought this to be a normal experince. He also described thought echo and the belief that the government had a special interest in him. He had an unusual manner and sidelong glances were frequent, with incongruous laughter. The patient was discharged to his bizarre flat (painted bright orange, somewhat squalid and covered in ropes of string) but his mental state deteriorated within a few months. He was treated as an outpatient but came to readmission at two years. He remained unemployed, unpredictable and occasionally aggressive and remained auditorily hallucinated. During his second admission he responded to oral neuroleptics but absconded after two weeks and refused to return.

145 LC 19 years Male Negro Eligible

LC was brought to casualty by the police following an incident in a public park with a police dog. The patient had severe lacerations of his leg. The casualty officer sought psychiatric assistance and the patient was promptly admitted to hospital.

The Present State Examination placed him within the nuclear schizophrenic category and he described possession by the devil and disorders of possession of thought.

His psychotic symptoms subsided but he was a poor attender and took his depot medication irregularily. Three relatively brief admissions followed within the next twelve months, on each admission the patient was psychotic. He continues to be in and out of employment, but when well gains work with relative ease.

The patient's brother is under the care of a local mental hospital and maintained on depot neuroleptics.

146 EA 29 years Male Caucasian Eligible

This patient, of Polish extraction, was very briefly admitted suffering from a paranoid psychosis. He was maintained on depot intramuscular medication from his general practitioner after discharge and made a good remission. Subsequent to his illness he left his parental home and joined his consort and her children. He maintains close contact with his mother who has since been diagnosed and treated for cancer of the breast. She describes him as well, but not his old self. The patient remains unemployed, as

he was prior to his illness.

147 MS 20 years Female Caucasian Eligible

The patient had recently married somewhat against her parents' wish. Both patient and spouse were active members of the Charismatic Church Movement. Over some months the patient developed increasingly bizarre religious ideas and began to wander at night and refused to leave the house by day. On admission she described herself as the Virgin Mary, believed her pregnancy to have arisen from immaculate conception and that she was carrying Christ. Delusions of persecution by other religious groups, notably the Rastafarians, were mixed with belief in magical powers to influence time and weather, and the patient described auditory hallucinations and disorders of possession of thought.

Treatment was complicated by the patients' quite genuine pregnancy, but after three months day care was achieved. Five months after admission MS was delivered of a healthy male child. Care was transferred to the private sector, but the patient remains impaired and reliant upon the support of her relatives.

There is a positive family history of psychotic illness both maternally and paternally.

148 MA 29 years Female Negro Eligible

The patient was admitted under Section 25 of the Mental Health Act, having become increasingly isolated and eventually refusing to allow her two children to leave the house to attend

school. She talked forcefully about a wide conspiracy of persecution, magical forces affecting her mind and body, and was hallucinated in every sensory modality. Local government and many statutory bodies were involved in the delusional network, the patient being convinced for example that her children's school books were made of human skin and the meat from a local butchers was human. She interpreted these occurrences as a warning to her of what was to come, and dated the onset of such events from a termination of pregnancy some years previously.

Admission for three months and high dosage of neuroleptics produced improvement. At 22 months MA is at home, supported by community psychiatric nursing services and social services. She copes with her two children (the patient is unmarried) and remains on depot medication. MA describes herself as much improved, experiences occasional episodes of thought insertion which she appears to have much insight into, but her main complaints of lethargy and loss of volition are severe.

149 YP 25 years Male Asian Eligible

This pleasant young man had recently taken part in an arranged marriage. He became preoccupied with ideas concerning his sexual function, and had this investigated, but no impairment nor cause was discovered. He later came to believe he was entangled in an experiment, under surveillance and an organisation was passing special messages to him via street signs.

He was apprehended by the police having driven up the wrong side of a motorway, and attempting to lift his car over a gate.

He was treated with neuroleptics and a short course of ECT during his admission of 44 days, but came to readmission within three months of discharge.

150 HC 42 years Male Asian Eligible

On admission this trained pharmacist gave a clear account of the sudden onset of psychosis. He believed himself to be the messenger of God, and that God's computer had taken control of him. Colours came to have special significance, amber being related to the deity, and he was fleetingly auditorily and olfactorily hallucinated.

He made a rapid remission and was maintained on lithium carbonate. At 20 months he remains well and working. The PSE placed him within the schizophrenic category.

151 CD 49 years Female Caucasian Trial Entrant

This tough cheerful Glaswegian lady had moved far from home a year prior to her illness. Her sociopathic adolescent son was in a hostel locally. She was admitted informally complaining that people were plotting to kill her, poisoning her with morphine and following her in the street and described hallucinatory voices chanting nonsense all night. Just prior to admission she had spent some hours in a public lavatory evading the cars which she thought were chasing her.

The psychotic phenomena receded but the patient never gained insight, and persisted reluctantly with oral medication for six

months. Twenty months later CD is living in a hostel, working as a domestic help and hoping to move to a flat with her son when he reaches the age of 16 years.

152 CH 22 years Male Mixed Negro Caucasian Eligible

One of a sibship of five, this youth had attended a school for educationally limited children. He had held some labouring jobs although he had attended a course to train as a television engineer.

He became extremely isolated and did not leave the house for six months. He refused to attend hospital but came passively for admission. His affect was disturbed with inappropriate smiles and giggles, he described definite alien thought insertion but refused to discuss other telepathic experiences because they were a secret. His grossly idiosyncratic speech displayed a surprisingly wide vocabulary.

This patient has since had many admissions, attended a day centre, and a hostel place is hoped for. He is grossly personally deteriorated and has a facial movement disorder.

153 SB 28 years Female Caucasian Organic

This patient had an organic illness.

154 JW 27 years Male Caucasian Trial Entrant

At interview the patient was grossly suspicious and hostile.

Reluctantly he discussed having smelt the ovens of a concentration camp at home, hearing voices called out "cuckoo" and the experience of his thoughts being broadcast by cables.

He made a rapid recovery and returned to his work in a fairly demanding but isolated clerical job in a library. After six months he refused further medication but was prepared to be seen at home. After two years he remains well, a slightly retiring man living at home with his parents and leading a somewhat limited social life.

155 DG 35 years Female Caucasian Eligible

A few months prior to this illness the patient stopped taking her anxiolytics, which she had used for many years. She began to hear the voice of God, and hallucinatory voices of relatives advising her to go to hospital. The patient was preoccupied with religious themes, fearing she had sold her soul to the devil.

After an admission of four weeks the patient was readmitted for six days some five months later. The question of alcohol abuse was never settled.

156 SG 16 years Female Caucasian Eligible

An intelligent schoolgirl from a middle class home, SG gave a clear account of her symptoms. She had experienced true auditory hallucinatory voices commenting on her thoughts and actions, and these male and female voices reiterated to her that she would never be well. She felt herself to be physically prodded by

unidentifiable forces, and believed witchcraft to be responsible for the insertion of alien thoughts in her mind. A prolonged and turbulent admission of fourteen months when SG repeatedly tried to return to school finally achieved this end. SG remains on depot neuroleptics.

157 HB 15 years Female Asian Eligible

This schoolgirl was referred to her local hospital when it became increasingly likely that her isolation and distress were due to psychotic phenomena. The core of her delusional ideas revolved around her belief that others were hypnotising her, interfering with her thoughts and in particular using their left hands to affect her head and mind. People around her became ghosts and terrified her.

After three months full inpatient care and a further four months day care HB returned to her school work drug free. Later she lapsed from outpatient attendance.

158 ES 30 years Male Caucasian Patient Refused Interview

This young man was admitted under Section 136 of the Mental Health Act and thence detained under Section 25 in a locked ward. At interview he was grossly hostile, refused to co-operate as he felt certain all around him were conspiring against him.

The patient lives with his mother who reported at follow up that he was now well. The patient's twin brother has been treated for schizophrenia at the same hospital for fourteen years.

159 BG 26 years Female Negro Eligible

The patient worked as a shop assistant and lived with her sister. She complained that strangers followed her and laughed at her in the street and of voices calling out "Betty is a stink bomb". She believed that thoughts were removed from her mind by electrical forces. Hospitalisation for five months was followed by day care attendance for six, but three months after that the patient refused all further contact.

160 OO 50 years Female Negro Organic

The patient had a possible organic illness.

161 CA 30 years Female Negro Organic

At interview the patient was disorganised and personally somewhat deteriorated. She conveyed in a confidential manner the idea that she held with total conviction that she was the African girl friend of a prominent young member of the Royal family. CA described a mass of referential ideas which confirmed her view and described true auditory hallucinations, both complimentary and derogatory concerning this theme. She had experienced hallucinations of a sexual nature and continued to do so in hospital.

The patient's child remained meantime in foster care, and CA spent over four months in hospital and a place was found in a

hostel. At 19 months CA continues to attend full time day care and her delusions are less prominent but still present, and continue to influence her behaviour.

162 AK 20 years Male Caucasian Eligible

This bilingual youth obtained and held a good job in an international bank, partly because of his linguistic ability. He developed the idea that others were referring to his sexuality and became grossly somatically anxious. He suffered from true auditory hallucinations constantly denegrating him. Six months hospital treatment was followed by full time attendance at a day centre, and at 22 months he remains in this situation. He continues to have delusions of reference and to experience thought transference daily but remains, despite his somatic anxiety, reasonably socially preserved.

163 AW 25 years Male Negro Trial Entrant

AW was admitted in a disturbed state, expressing bizarre religious ideas through a mass of thought disorder. He leapt from the third storey of the building believing himself to be pursued by the devil, and sustained spinal fractures which necessitated nursing in a plaster jacket.

He made a good remission and achieved excellent insight and later described hallucinations in all sensory modalities as having occurred. His consort refused to have him home and he went to a hostel and obtained his own flat. Within nine months he was in

full time manual work, maintaining contact with his children. At two years he is by his own account and objectively entirely well, a charming sociable rogue.

The patient's sister has very recently been treated for a florid psychotic illness. No other family history is known of.

165 IC 65 years Female Caucasian Eligible

Mrs C was referred by her general practitioner, and complained that the ghost of her deceased husband had plagued her over the preceding eighteen months, giving her bumps, making her spill things and laughing at her. She described being regularly confronted by this spirit at home when he stormed and swore at her in a most obscene manner, just as he had done when alive. On the basis of this IC had asked the local priest to exorcise the house, and had herself spent as much time as possible out of the home, on occasions just aimlessly wandering the streets.

At interview this plump garrulous lady was socially well preserved, and even at interview clearly auditorily and visually hallucinated.

The patient would only accept outpatient treatment, partly because she had care of one grandchild (in his late teens). At two years she remains fairly well and on neuroleptic medication.

167 OW 45 years Female Negro Unconfirmed diagnosis on PSE

The Present State Examination placed this patient in the depressive category. A six month admission was followed by community psychiatric nursing follow up. The patient refused further contact ten months after her hospitalisation.

168 BS 24 years Female Negro Eligible

The patient described a widespread delusional network centering on the belief that her mother was a witch, possessed of many powers. Thoughts that were not her own were transferred to her mind by others, principally her mother, and the patients own thoughts were transferred to people a long distance away by some form of telepathic communication. Early during hospitalisation BS had believed television programmes to be about her, but this phenomena had ceased. The patient denied ever being auditorily hallucinated but was frequently aware of the smell of frankincense and myrrh, which she could not account for. She believed her mother was trying to kill her and her children and expected her mother would kill her brother's children if she could, but believed the power of God was able to offset these evil forces. BS was also utterly convinced she was pregnant, the father of this pregnancy having left for Africa some six months previously. Despite the absence of any signs of pregnancy and a negative pregnancy test, the patient was not amenable to altering this view.

Inpatient care for four months was followed by attendance at a rehabilitative day centre for eight months. The patient is

currently supervised by psychiatric nursing staff in the community.

169 MR 23 years Male Caucasian Eligible

The patient lived in deprived circumstances with his mother, but had begun a chartered accountancy training. While on holiday abroad he became acutely ill, believed himself to be in paradise, and experienced thought transference and reading, along with true auditory hallucinations. All events around him indicated to him his special purpose. He made a slow remission but achieved good insight. However his function is impaired and MR has subsequently transferred to a more simple training and his initial excellent personal presentation is no longer evident. He tends to drink to excess and is frequently anxious and importuning at two years. He is well aware of his defect.

170 BW 21 years Female Caucasian Eligible

The only daughter of a self employed carpenter the patient's life had centred around her severely agoraphobic mother. It was for this reason that BW had never gained employment, but over some months she had become increasingly withdrawn and isolated.

On admission she described many nuclear schizophrenic features, believing herself to be under the influence of paranormal phenomena such as Black Magic, and described her hand being guided by these powers to write Chinese. Telepathic communication with a person called 'Mark' was a constant experience, and in addition to her thoughts being available to 'Mark' she heard his voice saying "you

are beautiful, I really love you".

The patient described all these experiences with some enthusiasm. BW made a slow and limited recovery and continued to attend day care after her discharge. She remained unemployed but eighteen months after the index admission was well enough to have her neuroleptics stopped.

171 JG 38 years Female Caucasian Unconfirmed diagnosis on PSE

This married school teacher suffered a serious psychotic illness with depressive features from which she made a very limited recovery. The question of an episode some decades ago in Australia was never entirely refuted.

172 AB 32 years Female Caucasian Previous Episode

This married woman had suffered a paranoid psychosis originally presenting as morbid jealousy. She very reluctantly accepted some outpatient treatment and improved, but came to admission three years later with a florid schizophrenic illness. She was excluded from the study on these grounds.

173 NC 20 years Male Caucasian Eligible

This patient of Irish extraction developed paranoid ideas following his return from a holiday abroad. He came to believe that agents of the British Government intended to kill him thinking he had contacts with the IRA. In the absence of depressed mood NC

believed that houses made of cardboard had been constructed to deceive him and that those who claimed to be his relatives were imposters. Further, he believed that the Government had interfered with his sexual organs.

The patient remained socially preserved and expressed his delusions less readily when taking neuroleptics. He absconded to Ireland whilst on leave and contact was lost.

174 LP 20 years Female Asian Eligible

LP had been found wandering around the local streets and a member of the public brought her to hospital. On admission she complained that gamma rays had beamed upon her, damaging her ovaries and causing her to bleed inside. She believed there were cameras in the walls of the place where she was living, which photographed her all the time, and that street names had been changed as part of a plot to confuse and harm her. LP also said she heard voices saying "you are a shit, you are a prostitute" when there was no-one about and nothing to explain it.

During the following days the patient became mute and resistive, at times exhibiting flexibilitas cerea, and she required intravenous feeding for some days. Treatment with neuroleptics was also commenced. Eventually the patient became responsive and indeed no longer held some delusions and had partial insight into her infrequent but persistant auditory hallucinations.

When fit to travel after seven weeks the patient returned to her parental home in Zambia. On two subsequent occasions the patient has returned to this country for review, but has not had a

further psychotic episode in the following two years. She has a moderately severe defect state, which has in part responded to reduction in the neuroleptics.

The patient comes from a comfortable home, her father is a medical practitioner. He described L as having for some years felt that people laughed at her, but she had done fairly well academically and functioned normally socially. One relative on the father's side suffered a florid puerperal psychotic illness. There is no other known family history.

175 DKB 15 years Female Asian Eligible

This pleasant pretty Sikh girl was referred to the child guidance clinic after experiencing difficulties at school, and came to admission five months later. She said something strange had happened to her which she could not understand. Despite her quite severe language problems she described the onset of perceptual abnormalities, followed by hallucinatory experiences. When looking at chairs and tables they twisted and distorted, and people's faces changed and became ugly. She felt her own face had changed, but could not describe it. Other people, especially fellow patients, seemed to have direct access to her thoughts and she felt that thoughts were inserted into her mind. A pseudo-hallucinatory voice which DB interpreted as that of God told her she was to be a prophet, evil spirits said bad things about her, and her grandmother's voice from India told her all would be well. DKB also believed herself to be the object of persecution, involving a governmental body who had installed a tape recorder at her home,

sent her messages through the television and employed people to follow her and to poison her food. She tried to describe the effect some external power had upon her mind and body, implying loss of control of her speech at times.

The patient was able to be discharged from hospital and day care after only two months and to return to school. After a year she remained well and her medication was stopped.

176 JN 40 years Female Caucasian Organic

The patient had a possible organic origin to her illness.

177 JO'B 28 years Male Caucasian Eligible

This 28 years old son of a pleasant working class family had been noted to be different from his usual self on return from a holiday seven years previously. Since that time JO'B had become increasingly deteriorated and erratic in his employment. For the two years prior to admission he had refused to attend the Department of Health and Social Security despite his unemployment and refused to see any medical services. He became restless and distractible, refused to wash or change his clothes and began to grimace and smile inappropriately.

On admission he was dishevelled and his affect markedly flat with bouts of incongruous grimacing. He described perceptual abnormalities such as his face changing into that of a woman and his thoughts being available to others due to his special powers of telepathic communication. JO was reluctant to discuss the idea that

he held periodically that others followed him and spied upon him, and contradicted himself when discussed auditory hallucinations. However he clearly described visual hallucinations, of solid cartoon characters, and was troubled by a persistent feeling of a presence trying to "take him over".

There was no known family distory bar one sibling who experienced a fleeting episode of "depression".

JO attended day care for eighty weeks and had not been discharged by the close of the study.

178 JF 20 years Male Caucasian Eligible

The patient was admitted from home via social services in a cachetic and unresponsive state. He lived in deprived circumstances with his father, a known chronically unwell schizophrenic and his mother who had been diagnosed in the past as manic depressive. He was extremely withdrawn, silent and absconded repeatedly. His behaviour on the ward was characterised by begging cigarettes, aimless wandering, and gross personal deterioration. He admitted to telepathic experiences and hallucinations in many sensory modalities.

Repeated admissions under compulsory detention occurred over the following months. At nineteen months JF was again hospitalised, on this occasion while his home was disinfested. His behaviour is marginally improved. He has never been employed and continues to be unable to co-operate with outpatient care.

179 MB 38 years Female Caucasian Trial Entrant

MB had a long established common law marriage and a child of eleven by this union. The prospect of formal marriage was combined with a proposed move, due to her common law spouse's occupation. The patient became distressed and indecisive over some months and became acutely disturbed. She feared she would kill her consort, ran off, and on one occasion misperceived her child as growing larger and larger. She experienced some olfactory auditory and tactile hallucinations.

Initially treated with neuroleptics MB improved but was rehospitalised three months later and made a good recovery with antidepressants. She returned to her clerical work thereafter.

180 JER 21 years Male Caucasian Trial Entrant

From a Roman Catholic background, the patient lived at home. Several of his large sibship lived fulltime or part of the time in the house which was perpetually chaotic. The patient's father, widowed some ten years previously, suffered a progressive neuromuscular disorder and by the close of the study was largely confined to a wheelchair.

On admission JER talked shyly of his belief in his own special religious purpose and explained how he averted road traffic accidents by the power of his thoughts. Although he denied true hallucinatory voices he hinted at such being the nature of his communication with God.

He made a fair remission, refused further medication, but not

contact, after nine months. At one year he started a retraining course which he did not complete. He was readmitted voluntarily at 20 months, coming to hospital under direct auditory instruction from God, and convinced that he was a saint, if not Christ reborn.

One sister has been treated for a psychotic illness, two brothers have sociopathic and alcohol difficulties and there is general family concern over the mental state of another brother.

181 RD 20 years Female Negro Previous Episode

The patient had suffered a previous psychiatric disorder aged 15 years necessitating six months off school and neuroleptic medication.

182 CK 46 years Female Caucasian Unconfirmed diagnosis on PSE

A somewhat forceful lady, CK denied any symptomatology whatsoever. She said she was in hospital because her husband had summoned the doctor, and repeatedly mentioned that her admission might have a deleterious effect upon her children. She also denied that her husband was deliberately trying to harm her, and although she felt his actions were misguided, she thought that by his own lights he was acting in her best interests.

The family however gave a clear account of progressively odd behaviour. The patient had ceased to leave the house over some years, and then ceased to pay any bills. She became suspicious and hostile, claiming that everyone was interfering with her post. She repeatedly removed the washing machine to the back yard, convinced

that some surveillance device was implanted in it, and talking of plots to kill her.

The patient discharged herself when the Section 25 of the Mental Health Act expired and soon refused all medication.

At follow up nineteen months later the patient was little changed, and her two eldest children were at university away from home. One son aged 18 had harmed himself deliberately a year after the patient's admission, and CK expressed grave concern for the boy whom she described as a very quiet withdrawn lad.

183 RK 20 years Female Asian Trial Entrant

The patient and her family had come to Britain from India following the Ugandan exodus. She was well and working as a laboratory technician in a college of higher education.

On admission the patient was disorganised with a fractured affect and described through her disorders of thought ideas of hypnotism, telepathy, magical and spiritual forces affecting her. She had several first rank features of schizophrenia but the overwhelming impression was of terror, convinced all around would kill her. The patient repeatedly referred to possession of mind and body by the devil.

A five month admission with high doses of neuroleptics produced total remission of psychotic features and the patient was highly compliant with follow up and outpatient care. She described herself as changed by the illness, lacking volition and drive and impaired in her enjoyment of all events. She described coherently a loss of sensation of taste and of sensitivity to cold, heat and pain. No

organic cause could be found and this sensory deficit appeared to be subjective. Her gait remained clumsy and later the patient developed mild involuntary facial movements.

At 22 months she requested readmission having become unhappy to the point of considering suicidal action, in the absence of other biological depressive features. The patient herself attributes much of her despondency to her lack of employment.

The family plan a holiday in India in the near future and possibly an arranged marriage.

The patient's brother has had two psychotic episodes in the past but has a minimal defect.

184 HS 19 years Male Negro Unconfirmed diagnosis on PSE

The patient was admitted in a state of terror, convinced that all around him intended to kill him. The Present State Examination rated him within the paranoid depressive category, and his twin brother had had psychotic episodes described as hypomanic. However his admission lasted four months and he was still attending fulltime day care at follow up twenty months after the index admission, maintained on depot neuroleptics.

185 LT 21 years Female Caucasian Eligible

This extremely pretty and glamorous young woman came to admission following a year of chaotic behaviour involving ill organised travel abroad and some six weeks of psychoanalysis. She was perplexed and suspicious, describing herself as under the

influence of the devil, and having watched her face change in the mirror. Auditory hallucinations kept her awake at night chattering on, saying "Far out baby" and she had both seen and felt a ghostly spirit leave her body.

Day care enforced by Section 25 of the Mental Health Act and treatment with oral neuroleptics improved her mental state.

Two years after the onset LT was much improved, and at the time of follow up nineteen months after the index admission, she was well, drug free, and attending a private psychotherapist, and had begun part-time work.

186 MW 30 years Male Caucasian Trial Entrant

MW sought help for sleep disturbance and impaired concentration, but these features had followed the onset of persistent auditory hallucinations. The voices were present at work and at home, and were both true and pseudo-hallucinations, saying "Here he comes", "where's the man" and referring, in a way the patient was not prepared to describe, to his masculinity. On the basis of the belief that the television programme had been designed to alter his career, MW telephoned the television company.

The patient and his spouse described a similar but much less severe episode that failed to come to treatment five years previously.

After eight weeks hospital care, MW returned to work. At two years he elected to persist with his oral medication, has good insight, and has been promoted at work. His wife is well pleased with his progress.

187 LD 28 years Female Negro Unconfirmed diagnosis on PSE

The Present State Examination placed LD within the manic category.

188 CJ 17 years Male Caucasian Transferred to Mental Handicap Services

This patient was educationally subnormal and care was tranferred to the appropriate services. It was not possible to perform a Present State Examination satisfactorily.

189 JC 31 years. Male Caucasian Previous Episodes

The patient had received neuroleptics with benefit three years previously and been diagnosed as schizophrenic and received day care briefly two years previously.

190 JM 17 years Male Caucasian Trial Entrant

An apprenticed tool maker, JC lived with his divorced mother and his younger brother in a well cared for home. He developed a brief paranoid illness believing his mother to be conspiring with

the BBC and had delusions of reference concerning the television programmes. He did not gain complete insight, but was otherwise well within three weeks of admission. He participated in the drug trial, but requested home visits to avoid time off work. Medication was discontinued after six months.

At twenty-two months he is a charming, spontaneous and normal youth, and has matured over this period. He has completed his apprenticeship and performed at a high level, and has formed an attachment with a local girl. His social outlets are many.

The patient's maternal uncle has been diagnosed as schizophrenic and had at least two psychotic episodes, with good but not total remissions.

191 EJ 17 years Male Negro Trial Entrant

EJ was described by his mother as always more shy, diffident and dependent than his siblings. He worked regularly in a protected environment but had no social outlets, despite his mother's encouragement.

He was admitted to day care, and described a complex delusional network largely involving telepathic communication with people from other planets. Tactile and olfactory hallucinations accompanied this as well as passivity experiences. He took medication reluctantly and viewed the reduction of these abnormal phenomena with distress. He was gradually reintroduced to his former employment after seven months day care, and maintains weekly contact with the unit.

His dependence and isolation continues to cause his family considerable concern.

192 VP 25 years Female Negro Unconfirmed diagnosis on PSE

The patient was disinhibited and extremely overactive. Transfer to a more secure unit was necessary. The Present State Examination placed her within the manic category.

193 GDH 20 years Male Caucasian asian Trial Entrant

This anxious and somewhat scruffy young man described sleep disturbance and somatic anxiety resulting from his many strange experiences. He believed himself to be the subject of persecution by his manager at work, to be followed around by strangers, and that this in some way was connected with a long past visit to a fortune teller. The faces of friends and acquaintances changed as he watched, became old, wrinkled and unrecognisable. True auditory hallucinations of a male voice that the patient believed to be his manager plagued him, saying "Go and show her to her seat. That's enough tea break". A female hallucinatory voice said "He's mad... He's queer, there's something wrong with him". The voices commented on his thoughts and actions. He described with distress an isolated episode of tactile hallucinations, something pushing him down the stairs. On occasion the patient found himself suddenly laughing or bursting into tears for no reason at all, and felt that he completely lost control of his emotions during these episodes.

An admission of four months improved the situation but GDH remains disconsolate and anxious. He remained outside hospital, working intermittently for nine months. He was admitted briefly but

was truculent and importuning, and took his discharge early only to be readmitted four weeks later. Plans were being made for hostel rehabilitation at the close of the study. The patient's management was complicated by persistent alcohol abuse when auditorily hallucinated.

194 AV 47 years Female Caucasian Eligible

An extremely well turned out petite and attractive woman, AV was initially highly suspicious of the interview. However she described many perceptual abnormalities and a paranoid delusional network. People who followed her appeared to have a yellow colouring to their skins and to be smaller than normal, appearing to be of a special unknown racial origin. She described people on buses reading newspapers containing a photograph and profile of her, and indeed made attempts to get a copy of the paper. Many items on the radio were about her, and on this basis AV ceased entirely to watch television, listen to the radio or read newspapers. She had become convinced that friends and acquaintances had changed towards her and believed that a gift of apples from a neighbour had been deliberately poisoned. She was also quite convinced that others had direct access to her private thoughts. In addition she believed her telephoned to be tapped.

The patient remained suspicious and prickly and took her own discharge after ten days. Contact was lost.

195 IB 20 years Male Caucasian Trial Entrant

For nine months IB had been moody and withdrawn, and latterly expressed the idea that he was being followed by others who wished to harm him. He became auditorily hallucinated and took an overdose in response to the voices saying "go and kill yourself or your family will be killed".

The patient improved in that his auditory hallucinations ceased and he was maintained on oral medication.

Within three months of discharge IB ceased his medication and became auditorily hallucinated again. He co-operated with depot neuroleptics for a few months, only to default, and ten months after discharge required rescusitation following a serious benzodiazepine overdose. Over the following three months the patient remained suspicious and hostile, unco-operative and intermittently hallucinated. He accused his mother of poisoning his food, of not being his real mother, of putting dope in his cigarettes. He was detained and treated under Section 26 of the Mental Health Act at this time.

Premorbidity IB was a pleasant, if perhaps a little impulsive, youth, had done passably at school and obtained City and Guilds examinations in plumbing. He had intended to join his father's business, but has not worked regularly since the onset of his illness.

196 JE 34 years Male Caucasian Eligible

This sullen man described himself on admission as "born to be a

prophet". He recounted how the experience of a presence some four years previously had been followed two years later by a single auditory hallucination instructing him to leave the merchant navy. On admission he described hearing the voice of God, the Devil and a female voice he believed to be of the Virgin Mary. These pseudoauditory hallucinatory voices had informed him of his special mission to convert Russia to Christianity.

After fourteen days the patient took his discharge, and remained insightless and deluded. However nursing staff in the community persisted with depot medication and after six months he no longer discussed his special mission and his self care had improved dramatically. At 15 months he remains outside hospital, unemployed, but co-operative with medication.

197 DB 28 years Female Asian Precipitous Discharge

The patient was uncommunicative and distressed on admission and a Present State Examination was not immediately possible. The patient's husband took her home after ten days. A month later DB drowned in a local canal and the coroner returned an open verdict.

198 FD 40 years Female Caucasian Precipitous Discharge

This married canteen assistant was admitted informally from casualty. Three weeks previously she had been investigated for possible melaena and at this time it was clear the patient believed her husband to be poisoning her. She described her belief that her husband had also interfered with her car, and how she had found

hairs on the bed that did not belong to anyone in the family. A stain on her spouse's car seat was believed by the patient to definitely result from sexual intercourse and she had interpreted a remark made by a work colleague "Why aren't you at work" as definite evidence that the woman was having an affair with the patient's spouse. Three months prior to admission the patient had heard burglars in the house on four occasions. The family denied any reality in this idea.

The patient was only prepared to stay in hospital for one night. A diagnosis of paranoid psychosis, morbid jealousy was made and treatment with oral neuroleptics commenced.

Eighteen months later the patient has abandoned the above mentioned ideas and remains well on small doses of neuroleptics.

199 TP 19 years Female Caucasian Patient Refused Interview

Following private psychiatric treatment with ECT, TP was admitted to her local hospital. During her stormy admission she accused nursing staff of controlling her mind by magic, was uncertain as to whether her parents were her real parents or not, and refused food and drink on the basis that it was poisoned. TP was hostile, overactive and at times perplexed and tearful. Fleeting ideas of reference such as the television programmes being about her, constantly recurred. She had also believed herself to be pregnant, that she had killed her parents and that she had become half man and half woman.

TP proved a most difficult management problem, but improved dramatically on small doses of depot neuroleptics.

However a year later she was detained under Section 25 of the Mental Health Act elsewhere.

200 AC 22 years Male Caucasian Eligible

Prior to admission AC had wandered off to America and later Ireland, causing considerable family concern. Admission under Section 60 of the Mental Health Act followed when AC put a brick through a window in Kilburn, intending to prove he was not involved with the IRA.

On admission he described how he believed he had been followed by people from different organisations. In Ireland it was the Irish Anglicans and the CIA, in London it was the KGB, and in other parts of London the CIA and the IRA. Involved in this network was a mass of religious delusions including AC's belief that he was Simon Peter and his friend was Jesus Christ, both reborn. He also believed his family doctor had been inserting thoughts into his mind and that friends of his had direct access to his thoughts. All these experiences were described with little affective change, and the patient had no insight into his condition at all.

Treatment with depot neuroleptics was started. After four months AC remained at home on leave, and completed a retraining course six months later. Medication was stopped, and sixteen months after the index admission AC is well and working.

201 TP 22 years Male Negro Unconfirmed Diagnosis on PSE

The PSE placed the patient within the manic category. He was readmitted six months after his index illness and placed on depot neuroleptic medication.

202 AM 21 years Male Caucasian Eligible

The patient who was unemployed, lived with his mother on the south coast. His mother had been maintained for years on depot neuroleptics. They travelled by taxi to the patient's sister, some 150 miles distant and the sister organised admission. The patient was uncommunicative but described true auditory hallucinations commenting on his thoughts and actions. He had believed these voices which had been persistent for three weeks to be due to his next door neighbours and was distressed to find they persisted in Luton. He believed that there was some serious malfunction of his sexual organs and had asked his sister to contact the hospital on this basis.

AM made a brisk recovery and was maintained on depot neuroleptics. Nineteen months after his index admission, he presents as a pleasant, slightly shy boy, seeming rather younger than his years. He remains unemployed but occupies his time to some effect. He is reluctantly persisting with the medication and has fair insight. He continues to spend a good deal of time in Luton and has a good relationship with his infant nephew.

203 AF 46 years Male Caucasian Eligible

Referred for assessment by the probation services, AF presented with an unusual mental state. He talked freely but in a circumstantial and indecisive style, constantly alluding to personal problems and asserting that he was not mentally ill. He was preoccupied with guilt over past often trivial episodes, and alluded with little conviction to the possibility of being under the influence of hypnotism. He did however describe delusions of reference and other partial held delusions. On watching television he became sure that false programmes told him they knew of his past. Things in newspapers were about his past life and he believed his conversations to be recorded. He believed that unspecified others wanted to kill him and described the outcome of the situation he found himself in would have an effect upon colleges and students.

AF had married for the second time recently, but had continued to stay at his old lodgings. Considerable social and domestic confusion surrounded AF's relationships with his first and second wife.

A Present State Examination placed AF within the possibly psychotic category. He was eventually maintained on depot neuroleptics and his perplexity faded. At fourteen months he remains well and working.

204 SW 24 years Male Caucasian Trial Entrant

This mathematics teacher was informally admitted with a four week history of increasingly odd behaviour. He had left his flat

and returned home, only to later leave and then return home again. SW took up sports and pursued them excessively, became uncharacteristically irritable and aggressive, unable to tolerate any music being played. He became preoccupied with incomprehensible life difficulties and expressed odd ideas, saying he should go to the police as his rent book was falsified and that he was teaching the wrong syllabus at school.

A few days after admission, SW became floridly psychotic, grossly formally thought disordered, his affect fluctuating from tears to elation over minutes. His general manner was distant, absorbed and perplexed. He expressed the beliefs that the television and radio referred to him and certain records on radio were chosen deliberately to remind him of his past life. He was convinced his food was poisoned and felt his head and genitals were compressed as a result of an aeroplane flying overhead. SW described thought insertion and thought echo and heard hallucinatory sounds of a klaxon, and occasionally single words.

This state persisted in the face of increasing doses of depot neuroleptics and a slow reduction in positive psychotic features became evident after four months.

Following discharge SW had severe disabling negative symptoms, and remained at home for some months. His insight was excellent but a lack of spontaneity and volition, and poverty of speech gradually improved. Steady reduction in the dose of medication was successful and one year after the index admission SW returned to teaching. Six months later at the close of the study, he remained free of psychotic features, but his family are well aware of his persisting defect.

There is a positive family history of mental illness.

The patient had a normal outgoing premorbid personality.

205 JB 28 years Female Caucasian Eligible

JB had come to London from South Africa and was sharing a flat with friends who organised her admission.

At interview she was casually dressed and talking forcefully, initially in a hostile fashion. She denied any form of mental illness but described many paranoid delusions. The patient was certain that unidentified others had researched her past life, and old movies on the television had been altered so that the story referred to her. She saw a flash of a man in a wheelchair on television, and identified this man as being her dead father. She was also convinced her neighbours were spying on her, that she was followed by a sputnick in the sky and that several organisations, probably including religious ones, were conspiring, perhaps to help her, more likely to harm her. A complex delusional idea concerning the front cover of the magazine Punch indicated that a new school of women's thought would improve things. The patient denied auditory hallucinations.

The present state examination rated JB as within the paranoid psychosis category.

The patient was discharged to bedsitter accommodation and thereafter had some temporary employment. Contact was lost but the patient was reported to have returned to South Africa five months later.

206 SJ 48 years Female Caucasian Serious Language Difficulty

Admission was precipitated by the patient burning all her household goods in the garden.

At interview SJ was dressed in two tee-shirts, a long jacket and skirt, a multi-coloured hand knitted rug, a black wig and a red head scarf. She spoke loudly gesticulating, and her speech bore little relation to the questions. The patient's native tongue was Hungarian and hence it was difficult to distinguish language difficulty from formal thought disorder with certainty, for example:

"I am not very old for marriage money I have twenty-five pounds in the office I'd give something why interpreter who speak French German what interpreter for my shoe and legs and what is wrong with body operation? I have two sons both go to school and never learnt it I do understand everything is money".

Day care attendance followed and an attempt to maintain SJ completely at home six months after the index admission date failed. At the close of the study 14 months later the patient was attending the day hospital once a week for medication, and still clearly unwell.

207 JA 28 years Male Negro Eligible

Admitted under Section 60 of the Mental Health Act, this slim Nigerian man described himself as having been assaulted. Previously he had held a post as a clerical officer for three years but had been unemployed for some months. He had married a patient who was a known schizophrenic, but they had separated prior to JA's

admission.

The patient had a somewhat formal and deferential manner and was reluctant to describe his mental content. However he believed he had had a special relationship with God for some four years, and had experienced true auditory hallucinatory voices, both male and female, over the past two months. These voices discussed JA and his actions and had kept him awake at night. He had felt his house was bugged and had a strong feeling that someone wanted to harm him.

His admission lasted four months and although his positive features receded he was slow, lacking drive and volition, but pleasant and compliant.

Within a few months he returned to Nigeria.

208 DR 22 years Male Caucasian Eligible

The patient had spent most of his early life in children's homes, and later received Borstal training. He was admitted following an incident where he climbed on to a railway track. Following brief hospitalisation he was discharged and almost immediately admitted elsewhere.

At interview he presented as a self possessed youth and described in isolation "voices" compelling him to acts of self harm. He denied any other psychotic phenomena.

He received after lengthy discussion a diagnosis of Personality Disorder from both the hospitals he attended and was treated with psychotherapy. Later he was discharged on no medication to a hostel. Contact was lost.

209 AP 24 years Female Caucasian Eligible

This pretty young woman had married sixteen months before her admission, and nad held a job as a typist in a local police station. For some months her behaviour had been odd and she had become increasingly vacant and disorganised.

On admission the patient spoke of her belief that the police had a dossier on her and intended to imprison or kill her. Many guilty themes were apparent, usually concerned with real and imagined neglect of her spouse. Auditory hallucinations spoke of her as a prostitute, and as being mad, and commonplace articles seemed to the patient to warn her of danger. She interpreted television programmes and magazine articles as having special messages to her from the police. Her grossly perplexed and distressed affect gave the patient an Ophelia-like quality.

Remission of these symptoms on increasing doses of neuroleptics produced enough improvement for AP to return home, and over some months she stayed with her parents, gradually resuming her own domestic duties. At eighteen months post admission she had obtained a job as a typist once more.

The patient's paternal uncle had been diagnosed as schizophrenic and died in a mental hospital.

210 BH 48 years Female Caucasian Eligible

This widowed lady had previously been working as a bank clerk. She described herself as becoming involved in a spiritualist circle and experienced true auditory hallucinations telling her to heal

others. The present state examination placed her within the nuclear schizophrenic category.

Mrs H took her discharge early, but was attending outpatients fourteen months later at the close of the study. She continued to have auditory hallucinations but enjoyed them, and had returned to part time work. Her cheerful personality appeared largely intact, and she refused to take medication.

211 CO 19 years Female Caucasian Trial Entrant

The daughter of an Irish family, CO developed insulin dependent diabetes at the age of 16. Her sister had been similarly affected since the age of 12. Six weeks prior to the index admission, CO had a "blackout", fell and was treated for a fractured nose.

She briefly returned to work, but her mental state caused concern and readmission and transfer to the base hospital followed. At interview she gave a good description of delusional mood, certain that many events were specifically arranged to test her and concerned lest others were conspiring to kill her. She was afraid her brain had been interfered with and believed that an artificial sun had been put in the sky for her alone, and was upset by the apparent expense caused.

CT's brain scan showed no abnormality, but EEG revealed delta and theta activity, prominent in the right temporal area.

The patient remained unpredictable, and absconded and took an overdose on one occasion. This however then settled, and she returned to home and work.

At eighteen months she is off all neuroleptics and a pleasant

cheerful normal young woman with many social outlets.

212 JS 33 years Female Negro Unconfirmed Diagnosis on PSE

Initially this attractive West Indian woman described her difficulties entirely in terms of marital strife. It became clear that the marital disharmony revolved around religious themes, and Mrs S believed herself to be a saint. Complex significance was attached to the silver cross the patient had purchased at a shop called David Smith, that the patient believed she was "given" the psalm of David to say, and that her parents were called Smith. She also spoke of another apparently unconnected delusional network involving the name Rose. Mrs S bought a picture of a rose and the lady in the queue behind her was called Rose. She believed her children were tormented at the local church by a lady called Rose and feared that "Lady Rose" wanted to harm her. On the basis of these ideas she examined all her old birthday cards and was extremely alarmed that many cards had roses on them, and became convinced that something odd was occurring that she could not comprehend.

She took her discharge when the Section 29 of the Mental Health Act expired, but was briefly readmitted under Section 136 of the Mental Health Act three months later. Contact was subsequently lost.

213 RA 26 years Male Negro Previous Episode

Admitted under Section 60 of the Mental Health Act, RA had been

unemployed for some months. His last job was that of a storekeeper, but three years previously he had obtained a BA in politics. Two years previously he had attended another hospital where the diagnosis of schizophrenia was entertained.

This was certainly the case on this admission, RA describing a mass of delusions of reference concerning the magic circle, thought reading and supernatural forces altering his voice. He was excluded from further study on the basis of a past diagnosis.

214 SL 30 years Female Caucasian Trial Entrant

SL worked in a clerical capacity for the British Broadcasting Corporation and lived at home with her parents. For the previous two years, the patient's mother had been seriously physically unwell and at the time of contact attended a day centre occasionally.

At interview SL presented as a plump woman looking younger than her 30 years. She described with appropriate distress how she had come to believe that others suspected her of having an affair with her employer. Telepathic communication had occurred, the above idea being inserted in her mind, and SL believed that she could similarly communicate with her mother over some distance. She was upset by hearing her thoughts spoken aloud in her head, and also preoccupied with her bodily function, although the latter did not appear to amount to delusional proportions.

The patient remained grossly anxious, and was readmitted to another hospital four months after her brief index admission. She has attended outpatients for a further one year (to date) but repeatedly refused further inpatient care. She has a longstanding

interest in homeopathic medicine which confounds drug treatment.

There is a positive family history of serious mental illness on her father's side.

215 GL 44 years Male Caucasian Unconfirmed Diagnosis on PSE

The present state examination placed this patient within the paranoid depressive category.

216 RC 36 years Female Caucasian Organic

This patient had an organic illness of possible aetiological significance.

217 EB 33 years Male Caucasian Trial Entrant

EB lived in working men's hostels and worked as a painter and decorator. He kept in touch with his sister and for some years had had episodes of unusual behaviour, appearing at his sister's home grossly dishevelled clearly having been wandering for days. During these periods he would express ideas concerning telepathy, but he repeatedly resisted his sister's efforts to seek medical help. At other times he would seem quite normal, outgoing and cheerful.

He came to admission from the hostel, and was clearly terrified. Some of his conversation was difficult to follow: "If I breathe without other people then they get stuck to me, I get stuck to people and the thoughts come through people. There are things I've learned just before I came in, it was so bad I could hear

everybody in my mind. It is like being stuck on the same wavelength as people'. He described watching his face become as that of a monster in the mirror, his past life being portrayed on television, and electrical forces and beams passing through his head. He believed himself to be the subject of unjustified persecution.

EB made a good recovery and gained employment. He had a fleeting period of entire well being and relapsed into florid psychosis at six months. He once again made a good recovery.

218 JW 43 years Male Caucasian Eligible

JW had a history of childhood epileptic fits that ceased when he was 14 years old. Despite a low intelligence he worked consistently in simple employment for seventeen years, and lived with his elderly parents. Some six years prior to admission he became unemployed, and for the last four years refused to claim any social security. During this period he developed episodes lasting months of bizarre behaviour, and these became well recognised in the local community. He talked openly to voices, giggled inappropriately and hid in cupboards and under the bed from his supposed persecutors. He became demanding of money and threatening, often wandering and being lost for days, only to return dishevelled and hungry. During these episodes his elderly parents regularly moved to other relatives, fearing for their own safety.

On admission JW described lucidly but in a simple style true auditory hallucinations saying "kill your Mum and Dad". He experienced broadcasting of his thoughts to a group of conspirators

who put smells in his room and made noises at night and who had, he believed, caused a local lady to become pregnant so that he would take the blame. The voices informed him that they thought him a homosexual and would take him to London, set him up there and extract money from him. He told of an incident where he identified a conspirator, whom he believed to be wearing a false beard to look like a neighbour, and how he hurled an iron bar at this apparent imposter.

He made a good response and was deeply grateful for the cessation of the voices, and was keen to persist with depot medication. He remains at home and attends a day centre. His parents have a lasting concern for his future after their death, hoping he will remain out of hospital.

219 CT 29 Male Caucasian Eligible

A history from the patient's parents revealed Mr T to have changed about eight years previously, and to have attended private psychotherapy for six years. His admission was precipitated by the patient carrying a sharpened axe around with him, and becoming increasingly distant and suspicious.

At interview CT was well presented but hostile, taciturn and tense. He admitted only to mild tension and confided he was writing a book, but would not elaborate. He refused further interviews.

He was discharged to an aftercare hostel after a protracted hospital admission, but left the hostel six months later. Contact was lost.

220 WKJ 21 years Male Caucasian Trial Entrant

WKJ left home aged 16 years and lived in a variety of "squats", being ocasionally casually employed. For the year prior to admission he had remained at home with his divorced mother, and had become increasingly isolated. He began to spend long periods staring into the mirror and laughed incongruously. He seemed unable to perform even simple self care.

At interview this scruffy youth was restlessly wandering the room, talking freely in an ecstatic style.

"For instance, you can foresight into future and work something out, if you can call out the worries and the tension right from the bottom then at one state or another the rise in tension will be extremely weak and if you change people's interests from saying the need to observe a new large phallic movements military to an interest in arks."

WJ described time distortions, non-verbal telepathic communication powers and having powers of prediction, and hearing his own thoughts spoken aloud in his head. Olfactory hallucinations of burning flesh and excreta had troubled him, and he had a wide range of delusions of reference concerning the radio and films sending him messages from the CIA.

He left hospital early, but later a place was found in a hostel. He continued to experience occasional bizarre phenomena, such as the face of a member of staff becoming like that of a wolf. These phenomena increased steadily, and he relapsed after eight months, but remained in the hostel. After one year in the hostel he left, and contact was lost.

221 KP 44 years Female Asian Trial Entrant

This lady came to Britain from Kenya, and helped her husband with his newsagent's business. Their three children were all in their teens and either working or studying at the time of referral. Mr P. described his wife as having become suspicious of him over the last two to three years, and of having become unable to manage the home for a few weeks. On admission Mrs P presented as a neatly turned out, pleasant woman, distressed that her thoughts no longer seemed under her own control. She spoke of derogatory thoughts concerning her relatives being inserted in her mind by an electronic device in the newsagent's shop. She believed that a white lady and her husband were conspiring to kill her and were responsible for these alien thoughts.

Mrs P insisted upon early discharge, but her positive symptoms remitted somewhat. Six months later the thought insertion became prominent again, and remitted with outpatient treatment. She remained well for ten months but again was psychotic at the close of the study. Her function has remained more or less impaired since the onset of the illness.

222 UP 35 years Female Asian Trial Entrant

UP, a married Ugandan Asian lady, lived with her spouse and thirteen year old son. Two and a half years prior to admission the patient became withdrawn and unable to talk to people at work. A holiday in India improved things fleetingly but Mrs P became unable

to cope with her domestic responsibilities. Previously she had held a job and managed well and prior to her marriage had worked for three years as a school teacher.

On admission Mrs P described true auditory hallucinations of female voices speaking an Indian dialect. She believed her head had split open and either a punk rocker or a cameraman had entered her mind and was interfering with her. A yellow rubbery thing burning inside her body was variously described by the patient as a heart or in the shape of a house.

Mrs P reluctantly consented to admission and improved. A few months after discharge she became psychotic once more, but responded to depot neuroleptics. Thirteen months after admission Mrs P is managing her home. She is now quite co-operative with medication and is seeking work, but with little success.

.223 CR 22 years Male Negro Eligible

CR stabbed himself in the abdomen and chest without warning. He required an exploratory laparotomy and was transferred to psychiatric care after this.

At interview he was extremely hostile, denying any mental illness. However his conversation was spattered with themes of suspicion which he refused to elaborate, such as a Jewish conspiracy, the people at work disliking him and the police wanting rid of him. He did describe a fleeting episode at work when the world looked changed and noises seemed strange.

His relative refused to discuss the situation and demanded CR's discharge. However he elected to attend outpatients after his six

weeks in hospital, and at fourteen months after the index admission, remains well and continues to attend.

224 ST 17 years Male Negro Eligible

The patient was initially shy and reluctant to discuss his symptomatology. He said he felt depressed and unable to concentrate and elaborated spontaneously:

"My arms and legs move, they move suddenly, but quite slowly. If I force them not to move it creates pain, and I cannot stop them moving, especially my legs".

"You will think I am crazy, but it is some outside force or power that moves me - they want to make me walk somewhere. It changes me and I feel uneasy. It takes over my mind a little - I start thinking differently. I have a little resistance when it is my legs but when anything comes into my head there is no way I can stop it."

ST also described true auditory hallucinations of male and female voices, giving him orders. He had previously confided in a friend that he thought the Hells Angels were going to kill him, and that he could hear their voices.

Six months of mixed inpatient and day patient care with high doses of neuroleptics diminished these features, but intermittent hallucinatory voices persisted. ST has remained at home well

supported by community psychiatric nursing staff, and a year after discharge has begun to attend a rehabilitation course at the local mental hospital. His personality is to some extent preserved in the face of ongoing positive symptoms.

225 SK 27 years Male Caucasian Not Seen

The patient was transferred to a hospital near his parents' home before he was seen.

226 JB 33 years Male Caucasian Previous Episode

A previous episode of manic depressive illness excluded the patient from further study.

227 AD 17 years Male Negro Eligible

This unemployed youth had clearcut features of schizophrenia, being convinced his thoughts were broadcast, and experiencing true auditory hallucinations commenting upon his thoughts and actions. He remained extremely slow, preoccupied and lethargic and either affectively flat or incongruous throughout his eight month admission. A period in the young schizophrenics renabilitation ward was followed by a place at a hostel, and day care attendance twice a week at a community centre was gradually introduced. Fourteen months after the index admission he remains severely disabled by his lack of initiative.

229 AK 37 years Female Caucasian Eligible

This married Greek woman was admitted for forty-eight hours in February and took her discharge. Ten months later compulsory admission under Section 26 of the Mental Health Act was organised. In the intervening months the patient had made three attempts at self harm, and on the last occasion required treatment in an intensive care unit.

In a demonstrative style with much affective change, the patient described herself as the object of the reciprocated love of a man who had once worked in a local supermarket with her son. She believed this man would come to take her away with him and that her family were preventing this. She had retired to the house and subsequently to her room over months and refused even to participate in such events as their daughter's wedding, six months prior to admission. The patient had constantly berated her family for their supposed prevention of her liaison. She described communication with her lover by forces of electricity, but would not greatly expand on this theme. By her own account she had met the gentleman on two occasions, both times briefly, in the company of her son. On the basis of the electric communication the patient had on several occasions left the house in the early hours, dressed as a for a party, and wandered around public parks, seeking her lover.

The gentleman concerned had left the country a year previously and made no attempt to contact the patient.

At six months the patient was slightly improved and maintained on neuroleptics, on leave from the hospital.

230 GJ 26 years Male Mixed Eligible

The patient was brought to hospital because he had slapped a woman. He explained this saying "She smells and has been put there to harm me, which is part of the plot against me". He talked to himself, described auditory hallucinations and thought broadcasting and believed that a ship in the sky was directing him. He refused to stay in hospital and his father supported him in this view despite giving a history of two years' deterioration in GJ's condition, culminating in violent behaviour over the last few weeks.

The patient took his discharge and contact was lost.

231 WB 33 years Male Caucasian Organic

This patient had a fifteen year history of serious drug abuse and was readmitted during follow up under Section 136 and later under Section 60 of the Mental Health Act.

232 CR 20 years Female Caucasian Eligible

The most striking feature at interview was CR's disorganised behaviour. She would sit for only moments in a chair and then wander the room, picking up articles and occasionally sitting on the floor. Her limited spontaneous speech consisted often of abrupt commands to be given something, it was almost impossible to gain her attention. She repeatedly removed her dressing gown and made highly inappropriate sexual advances to the male staff, and then tore bits

off a picture of a swan. She appeared neither depressed nor elated and moved slowly. She said that God talked to her, saying "Shut up and get out of here". When replying to an enquiry as to interference with her thinking the patient said "The thoughts go back to the swan. I want the cross to keep it for ever and ever. It depends on the soldier Marcus the nurse".

After six months in hospital, CR returned to her mother's home, and fourteen months after the index admission remains there, attending a day centre. She is now extremely lethargic with affective flattening and some incongruity persisting.

Prior to her illness CR had left home and was contemplating marriage.

The patient's uncle has suffered from a relapsing schizophrenic illness that began in his early 20s.

233 RH 49 years Male Caucasian Unconfirmed diagnosis on PSE

The patient had received outpatient treatment over years for somatic anxiety. He developed overvalued ideas concerning the effect that relaxation therapy might have had upon him. These did not amount to delusions and he was placed within the anxiety state category by the catego programme.

234 LR 22 years Female Caucasian Unconfirmed diagnosis on PSE

LR had been hospitalised for five weeks and discharged prior to referral. The initial picture was one of neurosis and the present state examination placed her within that category. Readmission

followed by one six months later which involved transfer to the local larger mental hospital.

235 DS 18 years Male Caucasian Rediagnosed Clinically Not Certainly Schizophrenic

An apprentice hairdresser, DS took his own discharge before he was interviewed by the research psychiatrist. His symptoms were predominantly depressive. At one year he remains well and out of psychiatric contact.

236 VI 18 years Female Negro Trial Entrant

On admission the patient was withdrawn and silent. At interview she spoke very little, and wrote some replies rather than speaking. She was convinced that others thought her face was deformed, and was unable to leave the house because of this. She experienced true auditory hallucinations which commented on her thoughts and actions, told her she was mad, and called her names. At times strange smells distressed her and she felt others had access to her thoughts. Her index admission lasted six months, and treatment with neuroleptics was supplemented by a short course of ECT and antidepressants.

Her father had left home, but had been admitted to a local large mental hospital, and her mother had received neuroleptics for two acute episodes, remaining well on oral maintenance treatment.

The patient was withdrawn from neuroleptics when she became pregnant, but occasional auditory hallucinations continue to trouble

her. She remains unemployed and lacks the volition to regularly attend a rehabilitative centre.

237 KM 18 years Female Clinician Requested No Interview

The patient's mother was a known chronic schizophrenic.

On leaving school KM held a job in a shop until a few weeks prior to admission. Her index admission lasted eleven months, and because of grossly disturbed behaviour the clinician requested the research team not to interview the patient.

238 SW 26 years Female Caucasian Unconfirmed diagnosis on PSE

A state entrolled nurse, SW had worked in psychiatric settings. At interview she was slow and vague, made poor eye contact and talked in a rambling fashion referring to mental conditions, hypnosis, blaming her parents, mother love and complexes. She believed that a blonde patient was in fact an actress, sent specifically to help her get over her mental condition. She believed that this was organised by a doctor she had been attending just prior to admission, and further that this doctor had caused her to fall in love with him by hypnosis. Certain colours had acquired special significance, green being somehow coneected with her SEN training and with schizophrenia, and yellow being worn by others to indicate that SW was less intellectually gifted than her sister.

The patient took early discharge from day care, and was treated by her general practitioner with oral neuroleptics. Thirteen months after the index admission she is much improved and working as an

auxiliary with mentally handicapped patients.

239 RG 27 years Male Caucasian Unconfirmed diagnosis on PSE

RG had left his home in Wales, seeking work in London. He had obtained a residential job as a barman, and admission was organised by his employers. At interview he had great difficulty in expressing himself, complaining of an almost total loss of emotional tone and gross impairment of his concentration. He recalled experiencing excessive energy and drive prior to admission, combined with special anticipatory powers. He had believed that regulars at the hotel were involved in an organisation dealing with thought anticipation and that he was being tested to determine his suitability to join the group. He had experienced some striking perceptual abnormalities on the day of admission, the inside of the ambulance alight with colour as in a kaleidoscope.

He denied however auditory hallucinations and could not describe convincing disorders of posession of thought.

He was transferred to Wales, and made a good recovery. Fourteen months later he was not on any medication living alone in his flat and fully employed with the social services.

The Present State Examination placed him in the manic category.

240 JO 19 years Female Caucasian Eligible

This pretty slim dark haired girl was initially almost unable to co-operate with interview because of her overwhelming distress. She described however how something strange had happened to her,

which she could not really understand. Colours of ordinary articles had become much too vivid and bright, and her face had changed into that of a rabbit, with furry ears and whiskers, while she watched in the mirror. She spoke of pseudohallucinatory voices of her dead grandfather, her mother and her fiance. These voices kept her awake at night, questioning her, saying "Who are you?" and occasionally discussing her relations with her fiance in a most personal and distressing fashion. Somatic hallucinations of a sexual nature had occurred, and she believed reference to be made to her engagement in the mass media.

After four months JO returned home, but remained lethargic and somewhat emotionally brittle. She was readily distressed by reference to her illness.

She married her fiance some six months later, and fourteen months after the index admission remains out of hospital, with no positive psychotic features, but rather more dependent and childlike than prior to her illness.

241 JJ 34 years Male Caucasian Trial Entrant

A trained freelance draughtsman, JJ lived with his Polish parents. He suddenly developed the conviction that a "central scanner" organised by a firm in the Midlands was putting him under stress and causing his thoughts to be available to others. His head

was moved against his will by this agency and he heard true auditory hallucinations. He believed the central scanner was making his feet smell. He was admitted and was completely insightless for two weeks when he suddenly remitted, and gained full insight. He remained well and gained employment abroad, but relapsed at six months and was returned to the U.K. He made a rapid recovery from this second episode and has since been maintained on depot neuroleptics.

242 CW 31 years Male Caucasian Trial Entrant

Five years prior to admission the patient converted to the Pentecostal faith, having formerly led a disorganised life involved in the world of popular music, pornography and drug abuse. Admission was precipitated by the patient repeatedly fasting for seven days at a time, in the setting of increasing religious preoccupation.

After admission the patient displayed more clearly psychotic phenomena, including definite auditory hallucinations of God and Satan saying "Be faithful" or "He is gorgeous". The patient interpreted black and white birds in the hospital grounds as conveying a special message for him alone, sent from God. He believed he had an important religious destiny, and forced his views upon other patients and staff. His conviction that food was an evil temptation continued to cause management difficulties.

The patient improved but his admission was protracted by the loss of employment and residence. Discharge to his mother's home after eight months was successful, and after a further nine months the patient regained employment, having discontinued his depot

flupenthixol.

243 PS 31 years Female Caucasian Eligible

The patient had been married to a successful builder for eight years. Three months prior to admission she gave up her secretarial job, and became increasingly withdrawn. On admission she described herself as having been chosen for a divine twin pregnancy, believing this to have been effected by electrical forces. True auditory hallucinations referred to the divine nature of this event.

The patient was herself an identical twin, but there was no known history of mental illness in the family. However the patient's father had lost contact with the family and was described as odd, violent, moody and socially isolated.

PS made a good recovery and was discharged from day attendance two months later. One year later she remained well, maintained on low doses of depot flupenthixol, with a well preserved social manner.

244 AF 37 years Male Negro Trial Entrant

AF had come to Britain from Grenada many years ago. At interview he described a florid and widespread psychosis, believing he had been poisoned and a tape recorder installed in his home. He believed others entered his home in his absence and stole things and had been greatly distressed by multiple true auditory hallucinations. These voices discussed his actions - "He's gone into the sitting room" and talked of putting bombs under his bed, or

in the bath. He believed this conspiracy to be perpetrated by an old girlfriend Chrissie, and had searched London for her. References to past events made a long duration of these ideas seem likely.

He insisted on early discharge, and his positive symptoms worsened after five months. He was treated at home with depot flupenthixol and remains at home, partially well, at fifteen months.

245 MD 17 years Male Caucasian Unconfirmed diagnosis on PSE

This youth had been slow at school and his milestones were delayed. However he held a simple kitchen job prior to admission. The Present State Examination placed him within the manic category and he was excluded from further study.

246 JP 50 years Male Caucasian Eligible

An unemployed steel erector, JP lived with his Polish speaking elderly mother and his sister in comfortable circumstances. A history of seven years duration of the patient expressing paranoid delusions with intermittent aggression and excessive alcohol consumption was obtained from another sister. The patient believed his neighbours to be involved with a vice ring, and had repeatedly contacted the police to advise them of this. He described auditory hallucinations swearing at him in Polish and attributed these to his neighbours, and believed his sister to be involved in the conspiracy. He had widespread delusions of reference which he interpreted as confirming this view.

Prolonged hospitalisation did not achieve insight although reduced the positive features, but after discharge the patient refused medication. Within a few weeks JP became increasingly aggressive towards his sister, and shouted all night to the voices. Readmission occurred at seven months post discharge. The patient retains a forceful personality.

247 RS 33 years Female Asian Organic

This medical practitioner was admited to psychiatric care puerperally. A diagnosis of cerebral cysticercosis accounted for her mental state.

248 JB 23 years Male Mixed Negro Caucasian Trial Entrant

JB worked unskilled in a warehouse. His early life had been disturbed by his father's violence, and he had been in care since the age of 11. Over some three months he had changed from a pleasant generous and quiet youth becoming restless, abusive and wandering at night. He ripped the telephone from the wall because he could hear derogatory voices coming from it.

On admission he described himself as having been poisoned by workmates, and attributed to two ladies from a local snack bar true auditory hallucinations. He believed himself to be the son of Mohammed Ali and to have a mission to help black people.

He made a moderate recovery but rehabilitation proved difficult. He briefly entered the drug trial was withdrawn but not rehospitalised. After a year he found a light engineering job

and remained well. His sister had a brief psychotic illness treated elsewhere a year previously.

249 DT 32 years Male Caucasian Previous Episode

The patient had a previous episode of psychosis treated as an inpatient.

250 GL 21 years Male Caucasian Precipitous Discharge

GL was admitted under Section 25 following an aggressive outburst at his day centre for the mentally handicapped. He was discharged early and not seen.

251 SM 20 years Male Caucasian Eligible

SM had a history of abnormality from the age of 16, when he became excessively shy and withdrawn. At eighteen he had private psychotherapy and more private treatment aged 19. On admission he was anxious and mildy depressed without clear features of psychotic depression. He had a number of fleetingly held delusions involving poisoning and persecution by anarchists and the Palestine Liberation Organisation as a result of his supposed unconventional attitudes, and complained of elementary auditory hallucinations of screams. On a few isolated occasions he described auditory hallucinations saying "Simon's wearing those funny jeans". His mental state fluctuated and was at times normal, but punctuated by fleeting delusional ideation and hypochondriacal preoccupations. A wide range of

medication was tried, the patient's fears of this confounding treatment. After three months he returned to college, was readmitted after five months but remained out of hospital over the following year.

There is a strong family history of major affective disorder and the patient's sister has a serious manic depressive illness.

252 SB 32 years Female Caucasian Rediagnosed Clinically Not Certainly Schizophrenic

The patient was admitted in a grossly deteriorated state, but had received outpatient treatment with neuroleptics the previous year, when she complained of auditory hallucinations of an ex lover.

253 DC 23 years Male Negro Trial Entrant

A likeable rogue, DC became unwell over some months. He complained of true auditory hallucinations of both male and female voices encouraging him to be a salesman. He said "There is something mystical happening, and I just cannot get the knack", and felt his thoughts were directly available to others. He made a good remission, achieved excellent insight, and returned to his flat. At six months he had a minor relapse and recommenced oral medication. Fourteen months after the index admission he remains well, cheerful and unemployed, but successfully living alone.

254 KW 21 years Male Caucasian Trial Entrant

This slim youth appeared much younger than his 21 years. He was admitted from his sister's home following some days of disturbance. He expressed a mass of delusions, believing himself to be the child of the Devil with alien evil thoughts repeated and inserted into his mind. Illformed hallucinations of music and tapping occurred, and KW smelt smoke and fire from his own mouth, caused by the Devil.

After much improvement he returned to his distant parental home. A minor relapse at six months was treated as an outpatient. He remains at home, markedly more childlike than previously, without however evident psychotic phenomena. There is a suggestion of a developing movement disorder.

255 DD 24 years Male Caucasian Eligible

DD had spent much of his youth in care, and was in lodgings working as a painter and decorator. It transpired that he was illiterate. On admission DD described his ability to communicate with his sister, many miles away, using psychic powers, and how others had direct access to his private thoughts. The thoughts went around his head as in an echo chamber and he said "All of a sudden I am stopped, like being in a force field". Auditory hallucinations accused him of homosexuality and he could smell flavours and perfume or a stagnant smell emanating from him. Reference to him in the television and papers distressed him and he also described a complex interwoven delusional network involving people from outer space.

DD drifted from day care, and when seen a few weeks later was psychotic again, his symptoms have previously at least partially remitted. He refused further contact.

256 BC 21 Female Negro Previous Episodes

This West Indian girl had had previous episodes treated elsewhere, four and two years previously.

257 JS 21 Male Negro Trial Entrant

The son of a diplomat, JS joined his sister in London to enter further private education. On admission he was pleasant but unable to co-operate fully due to persistent auditory hallucinations. Voices attributed to Uganda and America encouraged him to travel to America and be recognised as Elvis, and he identified one voice as that of a famous film star. JS described how his face changed as he watched in the mirror, becoming oval, becoming round, and believed this was done using a small medical instrument, and the voices similarly produced by electronic devices. On instruction from the voices he had wandered London protractedly searching for a house marked "12e".

He returned to Uganda after three months, but relapsed under psychiatric care there at a further five months. He reported himself as well after the elapse of ten months from the index admission, and is seeking another course of studies.

258 RT 34 years Female Caucasian Unconfirmed Diagnosis on PSE

The PSE rated this patient within the manic depressive category.

259 EC 39 years Female Caucasian Eligible

Admitted under Section 25 of the Mental Health Act, Mrs EC was strikingly perplexed and distant. She described herself as the subject of telepathy, referred to a large conspiracy of people who followed and watched her and believed that the television was altered, she was observed by it and that a bizarre perfume emanated from it. Elementary hallucinations troubled her at times. Her behaviour was unusual, she referred to her need for a brassiere repeatedly at interview and suddenly looked out of the window saying "I can hear the birds talking to me". Her child remained in care, and later gave a history of two years deterioration in her mother's condition. Six months hospitalisation was followed by fulltime day care attendance.

260 RA 30 years Female Asian Previous Episode

The patient had a past episode of psychosis.

261 EP 42 years Female Asian Serious Language Difficulty

Language difficulty precluded the interview. The patient had a marked movement disorder on admission.

262 RD 19 years Male Caucasian Trial Entrant

After RD cut his wrists his schizophrenic sister organised admission. The patient's mother immediately removed him from hospital. A month later he came to readmission following a violent outburst. At interview he was moderately well kempt, and a secretive smile and distant manner could change to brittle hostility rapidly. His sister described him talking of voices and telepathy but RD refused to discuss his mental content. He functioned in occupational therapy but remained isolated. He refused contact after discharge but sought psychiatric services six months later, following a legal difficulty.

263 EB 45 years Female Caucasian Unconfirmed diagnosis on PSE

The patient had a manic episode with religious themes predominating.

264 AS 41 years Male Negro Eligible

AS had lived in Britain for 20 years. His brother had been concerned when three years previously he became unemployed, after a good work record, and had subsequently led a vagrant life. The patient described auditory hallucinations and thought insertion, attributed to a man in the black hat who had caused AS to lose his mind. Some of his phrasiology was graphic, "The voices sweep out my thoughts" and "Nerves stretch out and touch my mind and then take

over".

The hallucinations persisted in the face of increasing doses of medication. The patient returned to Barbados when fit to travel, having arranged to leave Britain prior to his admission.

265 KP 41 years Male Asian Serious Language Difficulty

266 KK 35 years Male Asian Unconfirmed Diagnosis on PSE

KK and his wife and family came to Britain from Sri Lanka five years previously. The patient had fleetingly entertained fears of his wife's faithfulness at this time. This idea recurred and for the preceding two years KK had repeatedly accused his wife of infidelity. Arguments and violence and considerable interference with the wife's work as a night nurse culminated in admission when Mrs KK had left with the child to take refuge in a hostel for battered wives.

During his admission KK continued to act upon his apparently isolated delusion, repeatedly leaving the hospital to check up on his wife. The idea faded but did not vanish after treatment with flupenthixol was instituted. KK insisted after a few weeks on cessation of medication but remained improved and returned home.

Of good premorbid intelligence KK had worked as a hospital administrator in Sri Lanka, but had been unemployed since coming to Britain. Recurrence of the morbid jealousy caused readmission at one year. Twenty seven months after the index admission KK murdered his wife.

267 BW 21 years Female Negro Rediagnosed Clinically Not Certainly Schizophrenic

Following violent behaviour directed at her family, BW was admitted. She was restless, perplexed and taciturn. Repeated attempts at interview were refused by the patient. She remained suspicious but improved somewhat and was discharged after six months. Two months later she refused any further contact.

268 YB 28 years Female Negro Eligible

An attractive West Indian girl, YB had been employed as a secretary and planned to marry her consort. On admission she was floridly psychotic and grossly disorganised, having spent money excessively for some weeks. She described telepathic communication with an old boyfried and direct communcation with God, and direct passivity experiences when God moved parts of her body. Predominantly her mood was of elation but her affect was fractured as brief mute episodes occurred with no apparent change of mental content. Brief episodes of well being became more frequent and sustained after four months.

YB returned home, her consort having thought better of entering matrimony. Three months later readmision occurred, YB suffering from thought alienation in a setting of depressed rather than elevated mood.

A clinical diagnosis of schizoaffective illness was made.

269 PKK 20 years Male Asian Unconfirmed Diagnosis on PSE

The PSE placed the patient within the manic depressive category.

270 MB 34 years Female Caucasian Eligible

The wife of a severe chronic schizophrenic, MB, her spouse and son lived with the patient's mother, who is a hostile paranoid schizophrenic. MB coped admirably with these disadvantagous circumstances. Five months prior to admission MB suddenly experienced auditory hallucinations, and developed the idea that neighbours had poisoned the Christmas cake. Treatment with trifluoperazine was instituted by the general practitioners, but admission was required when MB stopped her medication.

The social situation of the family was grossly inadequate and the child moderately maladjusted. Admission was prolonged and rehousing achieved.

MB remained well for some two months but then fleetingly experienced distressing paranoid delusions, but refused to stay in hospital for long because of her spouse and child. The patient later attempted to leap from the window of her home and was subsequently compulsorily detained. The child was in the care of social services and MB made good progress. After discharge she gained simple employment and sought the return of her child, which eventually occurred successfully.

271 CM 99 Male Caucasian Not Admitted

The patient described in outpatients a brief episode of delusional mood associated with psychic powers. He refused admission.

272 CR 99 Male Caucasian Treated Elsewhere

The initial episode had been treated elsewhere.

273 RR 23 years Female Asian Deaf

The patient was totally deaf and formal interview not possible.

274 MO'C 38 years Male Caucasian Organic

The patient's psychotic episode was associated with alcohol withdrawal, with a long impressive history of alcohol abuse.

275 MET 29 years Female Caucasian Eligible

An attractive Irish girl, MET referred to partial delusions that others might wish to kill her, and made comments about the jealousy of her sister. She refused all contact.

276 RJ 19 years Male Caucasian Eligible

RJ held a simple job working in a butcher's shop alongside his

father. He had been recognised by the family as not entirely normal all his life, always slow, clumsy, limited and asocial. His parents feared this was due to their consanguinity, as first cousins.

Admission was arranged by RJ's parents when he became increasingly restless at night and complained of auditory hallucinations. These voices shouted abuse at him, in particular calling him "queer". At interview RJ also described his widespread ideas of reference, how the television referred to his past life and how he believed colleagues at work had put bromide in his tea. He described these features with a grossly flattened affect, and held partial hypochondriacal delusions concerning anaemia and diabetes.

Slow progress was maintained, RJ remaining at best a clumsy awkward youth with an incongruous and flattened emotional response. At one year he has returned to part-time work and attends day care on a regular basis.

278 DA 24 years Female Caucasian Trial Entrant

The daughter of a hotelier, DA had recently worked abroad as an entertainer. On admission she described her parents as identical imposters, believed her sister to be a lion, and felt hypnosis accounted for her alienation of thought. She was sure the telephone was tapped, electronic bugs were in the flower vase at home and a chemical smell came from these flowers.

There was a strong family history of psychiatric contact, single prolonged admissions having occurred in a cousin and a maternal and paternal aunt. The patient's father excessively abused alcohol.

A rapid improvement over days was followed by an admission of two weeks. DA remained very non-compliant, repeatedly refusing medication and having brief voluntary admissions for a few days each month over the following year. Her family are not able to persuade her to a more long term view. At one year the situation persists.

279 JP 26 Male Asian Serious Language Difficulty

Unable to drive, the patient nonetheless stole and drove a car away. Interview was confounded by a serious language difficulty, and his family organised a rapid return to the Asian subcontinent.

280 SF 22 years Male Negro Eligible

SF worked for British Telecommunication, and was most supportive to his mother, a late onset paranoid schizophrenic who also suffered from insulin dependent diabetes.

He was transferred under Section 60 of the Mental Health Act from prison to the local mental hospital. He described how microchips broadcast his thoughts all over Britain, and how electronic devices caused him to hear voices saying "Look at what you've done". He believed he was related to someone rich and famous and had widespread ideas of reference concerning "body language" used by conspirators to confuse him.

SF made a good recovery and was discharged after ten weeks. He later refused medication. Seven months after his index admission, he was once more detained in prison under Section 60 of the Mental

Health Act.

281 TD 26 years Female Caucasian Eligible

A pert forceful young woman with braided hair, TD described a conspiracy affecting her and those around her. She listed a mass of dates, times and names in elaborate detail citing apparently innocent conversations as proof of sinister events. She had experienced true auditory hallucinations and attributed them to former work colleagues, conspiring with the hospital staff.

Her father gave a history of loss of well being over two years, and said TD had not left the house for some months and become increasingly truculent, hurling abuse at her family.

When the Section lapsed TD took her discharge and ten months later remains as described, at home. There is no known family history. TD once held a secretarial post.

282 SBW 23 years Female Caucasian Eligible

SBW had joined her German born mother in Britain after separating from her husband. On admission following a massive overdose and wrist-slashing, she was quiet and withdrawn. Later she described the presence of auditory hallucinations over two years. Unpleasant olfactory hallucinations distressed the patient and later thought broadcasting and thought echo occurred. Throughout admission the patient was greatly concerned over her diagnosis, her twin sister having been diagnosed as schizophrenic some three years previously.

The patient took her discharge to rejoin her spouse in Brussells, but was readmitted in Britain at one year, having been hospitalised briefly in Germany at six months.

283 JB 35 years Male Caucasian Trial Entrant

Having worked as a welder in the Middle East, JB had been unemployed for a year. Following a courtship over more than a decade a marriage was planned.

He was admitted, terrified, believing his previous employers to be plotting to take over England and that he was to blame for relinguishing his faith by using Islamic phrases. A mass of delusions of reference based on his employer saying "You've made it" increased his fear.

He denied alcohol or drug abuse. JB rapidly improved and married as planned. He remained well, but lacking his previous drive and initiative. He planned to return to Libya but twelve months later was still awaiting a visa.

There was no known family history.

284 MO 20 years Female Caucasian Trial Entrant

The fourth of a sibship of twelve, MO and her family lived in three caravans, constantly on the move. Over a few months MO changed from being a helpful quiet girl, began to pinch and beat the younger children, wandered off at night, or lay chain smoking all day. She laughed and talked to herself and became grossly personally deteriorated.

At admission she spoke of multiple auditory hallucinations, believed herself to be pregnant and her sister's children to be hers, and feared her father would kill her. Ghosts and witches were mentioned, and she described delusional memories of filling a swimming pool with blood gushing from her mouth.

Progress was slow, but the positive features receded. Despite the family's itinerant life style she attended follow-up. She suffered a minor relapse at six months and came to readmission at twelve. Her family continue to be very supportive.

A paternal great uncle and a cousin have had schizophrenic illnesses, with poor recovery.

285 NG 34 years Male Asian Eligible

NG held a responsible job in sales, but became acutely unwell over a few weeks. On admission he was pleasant and articulate, but slow and insightless. He described how the magic of God caused him to hear voices of relatives from India, using a name "Narayan", thus referring to him as a god. He believed that pretty girls were sent to tempt him and that his sexual function had deteriorated. He was uncertain whether these events were planned to help or harm him, but talked of special television programmes put on for him alone, and believed his thoughts were freely available to others.

Improvement was very slow and whilst on leave he attempted to kill himself by setting fire to his clothing. Reduction of the positive features left the patient slow and flattened and he remains at home one year after admission, having been hospitalised for six months. He continues to have gross sleep disturbance and occasional

auditory hallucinations.

286 BE 22 years Male Caucasian Trial Entrant

One of four sons, BE had always been recognised as different from his siblings. He had a longstanding asocial trait, and had for years refused food other than chips and a handful of other items. However he held a job at the car works from some three years.

Initially referred for social skills training, he was admitted to day care, refusing inpatient care. BE was grossly unkempt and made no eye contact. He described himself as possessed of powers of hypnotism originating in his alien nature, and both feared and hoped his aliens would claim him for another world. Fleeting illformed visual hallucinations of flashes of light, mild perceptual abnormalities of altered sound volume and loss of emotional tone all distressed him. He repeatedly referred to suicidal preoccupations, and had for years believed others to be watching him with a camera. He felt he might have been a lorry driver in a past life.

Medication reduced the force of these ideas, but BE became incapacitated with akathisia, and developed copulatory movements. Despite many attempts with medication he remains most unwell, and has consistently required day care, refusing in patient care for all but three months of the year following referral.

There is no known family history.

287 MA 54 years Female Caucasian Organic

288 MA 28 years Male Negro Trial Entrant

On admission MA, dressed in colourful clothes with Rastafarian dreadlock hair described the onset of male and female voices six months previously. The voices said "You are coming with us, right", and he believed them to be due to magic, which also caused olfactory hallucinations so horrible they could not be described. At times he had had to leave all the windows open and leave the rooms to evade the smell. Thought insertion, thought echo and imperative hallucinations had troubled him, and he was surprised that these phenomena were not universally experienced by others. Somatic and sexual delusions were also present, but despite this MA had held a pressured job on the production line in the local car factory.

He made an excellent recovery, attributing his improvement to the strength the injections gave him against the magical powers. However he refused further depot medication as it reduced his sexual function. At six months his florid psychotic features returned, he was hospitalised and made another good recovery. At fourteen months from the index admission he remains well and continues to accept maintenance treatment.

289 DS 17 years Male Negro Eligible

The patient described how he had woken to a touch of a hand which he attributed to God, how he had leaped out the window and run to a relative's home. Here violence ensued, based in part at least on the patient's fear of all others and their apparent ability to

have direct access to his thoughts. His affect was flattened with fleeting incongruous laughter, and he described horrible olfactory hallucinations, thought broadcasting and partial delusions of possession by the Devil. Although prior to the onset DS had worked as a trainee painter and decorator, he showed no ability to organise himself. His admission to day care was spattered with violent outbursts, due to real or imagined slights and the patient's belief that others were against him. After three months he remained at home, but was readmitted under police custody after a further six months and remained hospitalised at one year from the index admission.

His mother remains horrified by the change in her previously compliant and helpful son.

290 MW 25 years Female Caucasian Eligible

MW had attended child guidance aged 16, been referred for excessive alcohol intake aged 20, and been seen at home once, aged 23, when she had not left the house for two years. Repeated contact with emergency services with complaints of palpitations and right temporal pain preceded this referral for inpatient care.

She presented as a grossly obese woman weighing 17 stone. Throughout interview she sipped a glucose drink from the bottle, and brought a suitcase of toilet rolls with her to the ward. She described how newscasters on television had direct access to her thoughts and having true auditory hallucinations of famous television personalities who she believed to be in the next room. Time had altered and speeded up and the patient accounted for this

with reference to Einstein and the belief that only she and a few knowledgeable elderly people were aware of time having changed.

The patient's father was attending elsewhere with problems of sexual identity and had a very close relationship with the patient. Admission had been arranged in his absence and on his return MW took her discharge.

She failed to attend follow-up but has been seen privately elsewhere, subsequent to her discharge. Some improvement had been achieved with oral phenothiazines and resocialisation.

291 MS 35 years Female Caucasian Trial Entrant

MS began to take an interest in spiritual matters four years previously around the time of the breakdown of her marriage. At this time she became auditorily hallucinated, hearing "I love you" and felt strongly that newspapers and magazines referred to her. These features persisted and the television seemed to the patient to imply she had joined the wrong company. Ill organised ideas of communication between countries and a plan to prosper everybody were expressed by the patient combined with references to thought insertion.

The patient finally consented to admission and became less dishevelled and disorganised. After discharge she obtained employment with little difficulty in computing services. One year after discharge she developed a movement disorder of lower limbs and pill rolling movements of her fingers. She remained rather socially blunted and overfamiliar. As the patient was of Yugoslavian origin a family history was not obtainable.

292 SU 29 years Female Asianic Organic

This patient had an organic basis to her illness.

293 DR 20 years Female Caucasian Trial Entrant

This pretty young woman was mildly dishevelled on admission, and behaved oddly at interview, lying on the floor and falling asleep. She reluctantly discussed her mental content, describing true auditory hallucinations complimenting her "Delrae, you're lucky", and believed these were due to her special grandiose powers. She made reference to thought alienation and displayed some suspicion, in the absence of elation or depression of mood. She improved rapidly.

Her father gave a history of six months loss of well being, where DR changed college courses for no reason, went missing for a week, and wrote three lines of gibberish in an examination. The patient explained how hallucinatory voices had advised her that the examination was a fake and how she could telescope three hours into five minutes in the examination.

Longstanding matrimonial disharmony had recently culminated in the patient's mother leaving home, compounded by recently being diagnosed as suffering from multiple sclerosis. The patient was concerned about the very close relationship she had with her father.

Following a rapid recovery DR was admitted for one night three months later, but took her discharge. At one year she remains well, but preoccupied with her weight and given to vomiting. This

is longstanding.

The patient's maternal grandmother has had psychiatric care but is apparently now well, her illness having originally begun puerperally.

294 PJ 17 years Male Caucasian Patient Refused Interview

The patient and his family refused permission for the patient to be fully assessed.

295 PB 26 years Female Negro Patient Refused Interview

This petite young woman consistently refused to participate in a formal interview. She remained distant and preoccupied throughout her prolonged admission.

The patient's mother described her increasing concern for PB. Over the preceding year PB was cohabiting and caring for her two children, and expressing the idea that neighbours thought her dirty, and she had complained of hearing voices. She refused relations with her consort in the belief that she was being watched, and then became acutely disturbed refusing food and attempting to harm herself with a knife. PB ran off having tried to jump from a window, and was taken to hospital by her relatives. Here she laughed incongruously, describing references to herself on television and radio.

Treatment was complicated by the patient's obvious suspicions, but eventually she returned home and attended partial day care.

296 AB 52 years Female Negro Eligible

A slim Barbadian woman, AB had become unwell following her divorce two years previously. On admission she described true auditory hallucinations of her ex-spouse and his paramour plotting to gain her home, and these phenomena persisted in hospital. She was distressed by this and by her thoughts being broadcast to others and referred to on television and radio, and felt that all others were accusing her of neglecting her children. The auditory hallucinations hurled abuse, often of a sexual nature, and telling her children to assault her.

Compulsory detention was necessary and Mrs AB improved somewhat, returning home after four months. She came to readmission six months later. Her personality remains well preserved with an appropriate affective response.

297 RS 25 years Female Asian Trial Entrant

RS described a mass of sexual delusions on admission, believing a fantasy lover had put a drug up her nose and raped her when she was asleep. She believed herself to be pregnant by this liaison, and hear true auditory hallucinations of this lover saying "You look like an Indian actress" and "I love you". Olfactory hallucinations were prominent, and she interpreted advertisements on the television as referring to her. Prior to admission she had removed her sari in front of her brother-in-law and become restless and disorganised. She described these events in the absence of elated mood.

The patient's spouse had a schizophrenic brother and had a good

grasp of his wife's condition.

She responded well to depot medication and was remorseful for the distress she had caused, with a well preserved social manner. Nine months after discharge she remains well, but slower and slightly lacking in spontaneity. At times the sexual themes recur but RS has insight into the nature of these phenomena.

298 IG 19 years Male Caucasian Clinician Requested No Interview

No information.

299 RN 22 years Male Negro Eligible

Admitted via the police RN described an illformed widespread series of delusions, involving persecution by the National Front who had drugged him and caused him to strip naked before the police. He believed that time was altered from one locality of greater London to another, that this related to references in newspapers concerning him and he had a special purpose. Isolated auditory hallucinations of Christ had occurred.

He took his discharge after sixty days and now leads an itinerant life style making occasional contacts with his mother. He remains out of hospital care eleven months after his index admission but his mental state is unknown.

300 GO 20 years Male Negro Previous Episode

The patient had an episode of psychosis five years previously.

301 BH 22 years Male Caucasian Precipitous Discharge

The patient took a precipitous discharge but came to readmission more than one year later, when a diagnosis of obsessional compulsive disorder was made.

302 WL 24 years Male Caucasian Precipitous Discharge

The patient absconded after four days and was readmitted three months later to abscond again. He had expressed paranoid ideas and was treated with depot neuroleptics, but a present state examination was not performed.

303 NN 47 years Female Negro Precipitous Discharge

Admitted under Section 25 of the Mental Health Act, the patient absconded repeatedly. A present state examination was not performed. The patient refused all contact with medical services five months later, having been maintained on depot medication for three months only.

304 DH 22 years Male Caucasian Not admitted (until 1 yr post referral)

Having failed to complete his undergraduate studies, DH was having difficulty with work. He discharged himself after two days. A Present State Examination at that time revealed unusual speech patterns that did not fully constitute formal thought disorder. More than a year later he was admitted, undoubtedly psychotic, expressing fears of ending his days in Broadmoor and suffering from gross thought disorder and some auditory hallucinations. He made a slow recovery over weeks.

305 CC 24 years Male Caucasian Unconfirmed diagnosis on PSE

This postgraduate student had a markedly asocial trait and a mild paranoid one and found himself at odds with his colleagues. There was no evidence of schizophrenia or psychosis at present state examination and his family thought him essentially unchanged from his usual eccentric self. He had come for assessment at his colleagues' instigation. He returned to his studies.

306 VB 20 years Male Negro Unconfirmed diagnosis on PSE

The patient was referred by the prison services. He spoke freely at some length expanding upon a general theme of prison life and his dislike of prison warders. It was not possible to elicit any features of a psychotic illness, although his speech was markedly circumstantial it did not amount to thought disorder. The

present state examination placed him in catego class "X" and a clinical diagnosis of personality disorder was made. He was readmitted six months after discharge, at the close of this study.

307 SS 18 years Female Asian Serious Language Difficulty

SS was an unassimilated Muslim girl from Pakistan, and was admitted practically mute. Language difficulties precluded an effective present state examination. After treatment with phenothiazines and electroconvulsive therapy, she made a good recovery and expressed poorly organised ideas of reference that she had held.

A relapse more than a year later proved more clearly to be affective in nature.

308 BW 44 years Male Caucasian Precipitous Discharge

The patient absconded and was not seen. Six months later he was readmitted for a month when a clinical diagnosis of schizophrenia was made.

309 WT 57 years Male Caucasian Trial Entrant

Of Polish origin, WT gave a heavily accented but coherent account of a florid paranoid psychosis. He had left his work of many years duration believing that others were threatening him. He believed that neighbours spied on him and the lack of interest the police displayed he interpreted as their involvement in the plot.

He described cameras watching him and was troubled by voices coming through the walls, commenting on his every action, knowing where he hid his money and when he went to the bathroom. On public transport he felt aware of others pointing at him and talking about him. The voices had referred to burning down his house and putting something through the letter box, and these voices persisted briefly when the patient was hospitalised.

He denied abnormal perceptions in all other sensory modalities.

He returned home, and a visit revealed his wife to be a forceful suspicious lady with inappropriate jocularity and some pressure of speech.

The patient refused all contact three months later and had not returned to work.

310 MA 21 years Male Caucasian Previous Episode

The patient had a previous psychotic episode, unspecified.

311 KG 37 years Male Negro Eligible

A well built West Indian man, KG clearly described how he had become a focus of attention and how the government had organised him being put on "a pedestal" by newspapers, radio and television. Others seemed to enquire as to his political beliefs, although he had no interest in racial or political issues. He believed in some way that he was the light of the world and felt a famous television personality had sung a song about and been involved with his hospital attendance. He was irritated by these attentions and

wished them to cease, feeling he had been randomly picked out for this attention.

He left the area to join his family and was treated as an outpatient after this three day admission. Eight months later he was well, medication free, and working as previously as an electrician.

312 NL 42 years Male Negro Trial Entrant

Mr L described himself as the object of persecution for the past four years, and for the week prior to admission he had become terrified for his life. Everywhere people seemed to follow him, talk about him and refer to his past. He believed that two cars had tried to run him down and believed neighbours had access to his private thoughts. Voices hurled abuse at him and he felt he was under surveillance. Fortunately his work situation was not incorporated in his delusional ideas, and a work colleague had organised admission.

His symptoms remitted but full insight was lacking. However he returned to live alone, and worked successfully once more for British Telecommunications as an engineer. At eight months he remained well.

313 PW 39 years Male Caucasian Trial Entrant

A practising member of the legal profession, PW had suffered rare grand mal attacks since adulthood. He developed a florid paranoid psychosis whilst on holiday and requested admission to

escape his persecution. He came to admission, however, when he contacted the police concerning this persecution.

He made a good remission with excellent insight but remained lethargic and slow, troubled by an excessive need for sleep. He did not resume his usual rather isolated pursuits such as stamp collecting.

One year after discharge he remains free of positive features of psychosis, but unemployed and although socially preserved, somewhat slow and lacking volition.

314 BJ 28 years Male Asian Trial Entrant

BJ lived with his sister who reported his behaviour to have changed over twelve months. Preoccupied with a trivial dispute with the landlord, BJ uncharacteristically sought legal action and repeatedly was out of work. He began to express the idea that the police were after him, that his food was poisoned and alluded to voices. An overdose of vitamin tablets resulted in admission.

His behaviour remained bizarre, childlike and importuning, and following reduction of his paranoid ideas he became facile, listless and his affect was flattened with fleeting incongruous grins.

This silly affect and pestering manner persisted on the patient's return to home, which failed after three months following discharge. Eight months after the index admission BJ attends a day centre full-time.

315 BD 31 years Female Asian Eligible

Admission was organised by the patient's brother, a general practitioner. BD had held a secretarial post of some standing for seven years, but became withdrawn, stopped work and remained at home for some months.

On admission she appeared perplexed and vague,felt others had access to her thoughts and were tricking her and complained of elemental auditory hallucinations. She wandered from the ward repeatedly.

Outpatient treatment was successful and five months after the index admission BD was working, sociable and competent and considering buying a car. Her other brother suffers a deteriorating psychotic illness and her mother was hospitalised for a psychiatric condition in the Asian subcontinent.

316 AAM 16 years Male Negro Clinician Requested no Interview

The patient was not seen for full assessment but had an extensive history of asocial behaviour and remained supervised by the probation services.

317 GC 21 years Female Negro Trial Entrant

GC had left home to move to her own flat, but over nine months lost her job, and moved again to a sister's home. For some weeks she was withdrawn and preoccupied with combing her hair, retired to her room and began to refuse to eat. Admission following her

running off and becoming grossly affectively incongruous, alternating between tears and laughter.

On admission GC described how she believed God had chosen her, how a fantasy lover had called upon her by God's arrangement, and unusual beliefs that time had gone backwards so that she was only six years old. Themes of plots and ideas of reference intertwined with these ideas, and she complained of male and female voices leading her on. The patient was distressed by her loss of control over her emotions, aware of weeping and laughing for no reason.

She made a good recovery and quickly gained at least partial insight. Eight months later she remained well but still unemployed.

318 AH 16 years Male Caucasian Clinician Requested No Interview

The clinician requested the research team not to visit.

319 LA 27 years Female Negro Previous Episode

An unspecified past psychotic episode precluded further study.

320 JR 21 years Male Caucasian Eligible

Over four years JR had become preoccupied with the theme of unrequited love for a girl he had had very limited social contact with. In a setting of increasing withdrawal and repeated deja-vu and depersonalisation experiences, religious delusions formed. JR believed himself to be Christ reborn, and that God's special purpose would be revealed. Complex ideas of reference incorporating

the letter Y, his religious destiny and his work as an apprentice engraver were poorly described, the patient lapsing into formal thought disorder.

His family confirmed their increasing concern for the patient over years, and that he had expressed ideas of marriage to the girl with an intensity quite out of keeping with the reality of the contact.

Eleven months after the index admission he remains not entirely well and socially isolated, but at home and fully employed in shift work, having given up his apprenticeship.

321 JR 22 years Male Caucasian Trial Entrant

Whilst abroad on holiday JR became acutely unwell, convinced his food was drugged, people wished to kill him, and that others knew and made reference to his past life and experiences. He described himself as able to speak two foreign languages fluently while on holiday, but also experienced his eyes as being controlled by an outside malevolent agency.

On admission the patient was clearly terrified. However he made good progress with excellent insight, and joked about his previous beliefs.

He returned to his factory work, but remained a rather tense, anxious and socially diffident youth. Sixteen months after the index admission he relapsed and was readmitted. There is a question that he has for some years drunk to excess.

322 JD 24 years Male Caucasian Unconfirmed Diagnosis on PSE

This law student had an unequivocal manic illness. His mother had a long history of serious affective disorder.

323 PC 29 years Male Caucasian Eligible

PC was referred for assessment having been relieved of his duties by the Civil Aviation Authority. He presented as a meticulously groomed man with an abrupt and somewhat military manner. He denied any form of illness but spoke of his telepathic communication with a famous female popular singer and referred to a force as having guided him to this lady. He believed that a doctor had relayed messages from this singer to him and quoted coincidences as examples of proof of his connection with this lady.

The patient's brother committed suicide whilst attending psychiatric care two years previously, coinciding with the first noted change in the patient's behaviour.

324 TK 30 years Male Caucasian Eligible

Five years previously TK had unexpectedly left his job, and become a recluse. Keeping a room nearby his parents TK refused any intervention in his life style, and despite his parents' efforts became personally grossly deteriorated.

On admission he presented as a blank faced quiet and unkempt man. His speech was grossly bizarre. "I would hope that a spiritual void or a bottomless pit does not turn up, a revolving can

or a cylinder. That is just an effect, it is not real. Take the example of a headache. A person has a bad headache and their head becomes larger as if it were bigger, they are the symptoms of a headache."

He has made very limited progress and remains odd, quiet, and personally deteriorated with very unusual speech. He remains hospitalised at one year.

325 HL 38 years Male Caucasian Previous Episode

The patient had been treated in Europe for a psychotic illness five years previously.

326 OB 20 years Male Negro Eligible

The patient left Ghana to join his mother in Britain and obtain higher education. It became clear to his mother, a trained nurse, that OB was unwell, and he made repeated sexual advances to his mother.

On admission he spoke in a whisper, describing voices, distracting him from the interview, and mentioned his special communication by telepathy with these voices and with God. He described clearcut olfactory hallucinations, pleasant smells and also rotting bad smells. He felt his food had been tampered with, that relatives were plotting to kill him, and described these with an affect spattered with inappropriate giggles and whispers.

He made a slow and partial response to depot medication. Thirteen months after the index admission he held a portering job

and his mother reports him as well, and free of his abnormal ideas. She had discovered subsequent to her son's illness that a paternal cousin of the patient had had a serious psychotic illness.

327 WFN 32 years Male Caucasian Previous Episode

The patient had come to Britain fifteen years previously and had been required to take oral chlorpromazine at that time. A past psychotic episode was presumed.

328 NS 17 years Male Caucasian Organic

The nuclear schizophrenic features this attractive boy presented with were attributed to massive ingestion of many illegal drugs, and full examination of the question confirmed this.

329 EB 39 years Female Caucasian Trial Entrant

An unsuccessful marriage had culminated in divorce many years ago, and during the last two years Mrs B had lost contact with her errant daughter. She continued to work full-time as a secretary and maintained her own home in outer London, spending the working week staying in central London with her parents.

Mrs B described a mass of bizarre beliefs and experiences, including a physical sensation of 'something coming up and over' which were thoughts from other people on their way into her mind. She believed herself to be functioning like a transmitter in that her own and other thoughts could be broadcast through her brain, and

others could remove thoughts from her head and could read her thoughts. Simple hallucinations of discreet words such as her name or nonsense such as "nanu nanu" caused her to laugh, to the degree that she experienced urinary incontinence. Mrs B experienced olfactory hallucinations, the smells ranging from burning and exotic flowers to human excreta. Mrs B spoke freely of her unusual experiences with any trace of disquiet, describing herself as under the control of God with spirits inside her that she could feel, and was convinced that the doctors were actors and negroid patients members of a popular musical production.

Mrs B made good progress on oral medication during two months in hospital, and achieved much insight. She remained a pleasant co-operative lady and returned to work within weeks of discharge. Six months after discharge she remained well with no obvious defect and her daughter had made contact with her once more.

330 PM 32 years Female Caucasian Eligible

PM had one of the most well-organised and fixed delusional networks the author encountered in the study. The patient had had a disturbed childhood and left home in early adolescence, leading the life of a travelling street artist. A child of a longstanding liaison was in care in Europe. Although the patient repeatedly denied past psychiatric contact she had been deported from various countries, and at the time of admission was resident in a church hostel.

She believed herself to be under the influence of chemicals introduced into her body as food or drink by any of some three

hundred persons with whom she had recent contact. She was convinced that this was part of a worldwide conspiracy of Russian origin and that she was under constant surveillance. Olfactory hallucinations of burning rubber and anaesthetic gases the patient interpreted as the influence of the chemicals upon her mind and she was concerned that her body gave off an offensive odour. Delusions of impending disaster, predominantly in the form of the conspiracy taking over the world, were prominent. The patient described these features with an appropriate degree of distress.

Throughout her inpatient and day patient care, which lasted six months the patient was reluctant to accept even small doses of medication. She was a talented artist, occupying her time to effect in drama and art. She then took her discharge abruptly and left for the continent.

331 AC 39 years Male Negro Eligible

The younger son of a chieftain in Ghana, AC came to Britain to take accountancy examinations. He was admitted after holding a knife to his wife's throat, accusing her of infidelity. A four year history of increasing preoccupation with this theme was combined with the patient expressing fears of a plot against him with delusional intensity. AC interpreted common place events as confirmation of his ideas and had followed his wife in attempts to find her imagined lover.

A diagnosis of paranoid jealousy was made, the present state examination placed him within the possibly psychotic category. Within a few weeks he gained insight into his ideas and believed he

must have been ill at the time. He was anxious to persist with medication, and remained socially intact.

The research team lost contact with AC some weeks after discharge.

332 DR 35 years Male Caucasian Trial Entrant

A thin diffident man, DR looked older than his years and was neatly dressed in a precise rather military manner. He lived with his elderly father and aunt, and travelled daily some forty miles, to his work in a solicitor's office.

For two months he had felt others were talking about him, and on the basis of these apparent comments removed his moustache. He described himself as receiving messages via an electronic device in a helicopter and believed this communication to come from the father of a female colleague. In a conspiratorial tone he asked that reference to the helicopter be deleted from his records. He had clearly developed the idea that others thought his intentions to the female colleague to be dishonourable and that the father of this lady would inflict violence upon him. He also expressed, with no emotional response, the belief he had held, that his own father was dead.

DR made a rapid recovery gaining some insight and being somewhat embarrassed by his illness. He returned to work and was well at six months, but was slower than previously, and had a movement disorder of his hands and feet.

333 DR 26 years Male Caucasian Eligible

The Present State Examination placed this young man within the S+ category but he was transferred elsewhere and left the area.

334 EF 26 years Male Caucasian Unconfirmed Diagnosis on PSE

The patient complained only of neurotic symptoms which were in part related to alcohol abuse. He had a mass of social difficulties and attended as a day patient for some time.

335 GP 22 years Male Negro Eligible

Following deportation from the United States and a charge of arson GP was constrained by Section 60 of the Mental Health Act. At interview he complained of somatic anxiety related to his concern over the impending court case and to his fear that he was about to be attacked because he was a member of the Conservative Party. When asked about auditory hallucinations GP was reticent, but described having seen brightly coloured unidentified flying objects in America, and more recently a spaceship in the sky above Luton. He also believed a woman from the church of Scientology had hypnotised him, that communists tried to insert alien thoughts into his mind by

telepathy and was able to interpret general events reported on radio, television and in newspapers as evidence of the activities of these two organisations. He described the purpose of the scientologists was to aid him to become a world leader. Initially the patient was clearly suspicious, but became relaxed and co-operative during the interview.

The tendency of GP to be very reticent made assessment of his progress difficult. He was discharged to a hostel after five months inpatient care, the Section 60 of the Mental Health Act still in operation.

336 MAG 24 years Female Asian Eligible

MAG was admitted after being brought to hospital by the police. She had behaved in a bizarre inappropriate manner in a large department store.

On admission MAG presented as a slim pretty young woman, grossly perplexed and sad. She complained that she had felt changed since the birth of her child a year previously, had begun to hear voices talking to her and was hearing her thoughts spoken aloud. MAG was uncertain as to whether the child was hers, or had been born to her sister, and believed she could hear her sister in Malaysia talking to her. She remained bewildered and wandered from room to room and scribbled meaningless things on notice boards.

Prior to admission the patient had been completing studies in chemistry.

MAG was taken home to Malaysia with the assistance of her embassy within a few days. Contact was lost.

337 MW 25 years Male Caucasian Unconfirmed Diagnosis on PSE

MW complained of depression and suicidal ideas, and had recently taken a quantity of tablets with a large amount of alcohol. On waking from this ill-organised attempt he was briefly hallucinated. He had no other features suggestive of psychosis, but described longstanding alcohol abuse, social and marital difficulties. He was excluded from further study.

338 JOS 23 years Male Negro Eligible

Initially the patient was reluctant to be interviewed. However, he described himself as perfectly well, in fact two or three hundred per cent better than normal. A male voice which the patient identified as God has been speaking to him, saying "you can have anything you want'. The patient had hallucinations in other sensory modalities, describing a tactile sensation of the hand of God upon him and pleasing smells coming from heaven. He believed he had the power to see right around the world and that he was Saint John. He felt cheerful, was thinking rapidly, and some of his conversation was difficult to follow.

After a brief admission when JOS was detained under Section 25 of the Mental Health Act, the patient left the ward and refused all further intervention.

339 SG 30 years Male Caucasian Previous Episode

The patient had a manic episode characterised by religious delusions. He had suffered from a manic depressive episode eleven years previously.

340 ZS 24 years Male Asian Trial Entrant

This unemployed Asian man lived nearby his uncle, his only relative in this country. He described how things began to look different from normal and he had heard inexplicable noises over the preceding weeks. His admission was precipitated by an unprovoked attack upon a neighbour.

He described clearly male and female voices speaking both to him and about him in the third person, using the Urdu language in a vulgar abusive way. He had noticed bad smells of no known source and believed these abnormal experiences to be due to the use of a video machine. At interview he adopted unusual postures, gazing at the ceiling for minutes at a time.

He made fair progress but his grasp of the illness was limited. He was discharged home after one month and remained out of hospital but unemployed until the study closed ten months after the index admission.

341 MP 23 years Male Asian Unconfirmed Diagnosis on PSE

The patient had a manic episode and was excluded from further study.

342 LJR 28 years Female Caucasian Trial Entrant

A slim vivacious woman looking younger than her years, LTR cared for her seven year old son at home. She had divorced her spouse but the relationship continued, with intermittent separations and repeated episodes of violent discord.

On admission LJR said that the illness had begun three months previously after a spontaneous abortion. She described true auditory hallucinations of two male voices of people known to her, who discussed her and called her a whore, saying such things as "What is she doing?" "She is in the loo". She believed these voices could read her mind and also described thought insertion. Occasional olfactory hallucinations of peppermint or bonfires were inadequately described but she believed she had suffered 'astral projection' and that her abnormal experiences were designed to encourage her to use her psychic powers. Clear cut delusions of reference, including television newscasters referring to her, were widespread.

The patient responded to some degree to medication but fleeting auditory hallucinations persisted. She returned home after three months and changed work from a telephonist to a machinist within the same workplace. She stopped all medication and her psychotic experiences increased, and she was persuaded to resume her drugs.

Five months after the index admission she continued at home, working full-time, but with ongoing positive features.

343 BW 35 years Male Caucasian Previous Episodes

This simple man had suffered from many previous schizophrenic illnesses.

344 GQ 27 years Female Negro Eligible

A machinist, Miss Q came from Ghana and lived alone in a bedsit. She derived some support from her local fundamentalist church. On admission she described herself as being increasingly upset by her landlord's harassment. She believed strangers to have followed her in the streets and that cars stopped, false workmen watched her, and that the landlord wanted her to leave. Admission had occurred after Miss Q had screamed all of one night.

After four weeks in hospital the patient was much improved and gained partial insight. However she was readmitted three and a half months later, when her mental state was characterised by religious themes and constant auditory hallucinations advising her to buy or not to buy things. She believed these had occurred as a consequence of being drugged.

She was discharged a month later, just as the study closed.

345 HRJ 24 years Female Caucasian Eligible

Following her second confinement Mrs J became withdrawn and occasionally perplexed. Months of unusual behaviour preceded admission.

At interview she presented as a slim woman, casually dressed.

Her affect was perplexed and her behaviour hesitant. She spoke at length, some of the conversation was difficult to follow, and mostly conveyed complex delusional ideas. She believed she was pregnant due to telepathic forces from another patient, and that she was stealing energy from other people by looking into their eyes. She was convinced all around her had access to her private thoughts and experienced true auditory hallucinations, including some of a fellow nursing student called Michael. She believed this old colleague to be the archangel and described other religious delusions as follows: "I realised that we were thought.... peace is God, therefore when my little boy came out he was so peaceful and God really and he is really Christ. I feel that Roy is really God, God has many faces". At times the patient believed she was dead and could smell the rotting of her body.

A trained nurse, Mrs J had recently been a fully occupied housewife. She made steady progress and her affect improved. After two months she was free of psychotic experiences and was transferred to a mother and baby unit, and reunited with her child. A month later she returned home, maintained on minimal doses of oral medication. Six months after the index admission she remains well.

346 DG 27 years Male Asian Eligible

Admission was precipitated by a violent outburst at home, the culmination of two years of increasingly withdrawn behaviour. The patient's mother described him as a quiet boy with no friends who had always been unlike her three other children, and described her increasing concern for over the last two years, especially when he

became unemployed.

At interview DG was remarkably guarded, displaying a flattened affect broken with incongruous grins and distant hostile supercilious looks. It was not possible to elicit clear delusions or hallucinations from him. The present state examination placed him within the undifferentiated possible psychosis (UP?) category, and a clinical diagnosis of schizophrenia was made. Despite DG repeatedly demanding to go home he could not decide whether or not to attend day care. Discharge to employment occurred after one month. Six months later he remains employed and attends regularly and voluntarily for his depot medication.

347 MW 23 years Male Caucasian Not Seen

MW took his discharge within three days and a present state examination was not performed. He continues to attend outpatient follow-up, and was charged with indecent exposure six months after his initial referral. The clinical diagnosis is uncertain, and drug abuse may be implicated.

348 AP 37 years Female Caucasian Eligible

AP was married to a business man, and cared for her seven year old son. She had been employed part-time as a playleader but ceased work some six months prior to admission. The patient's husband had visited Russia on business on several occasions, and the patient began to fear he was a spy. This preoccupation assumed delusional intensity and was combined with delusions of reference, including

the telephone being tapped and being convinced she was under surveillance. AP left her home and returned to her parents in the countryside where she expressed fears for the safety of herself and her son.

On admission Mrs P was perplexed and anxious and deluded. Hospitalisation for a little longer than one month was followed by day hospital attendance. She remained anxious but less preoccupied with her delusions and six months after the index admission remains at home, attending outpatients and maintained on oral drugs. The patient had a brother who committed suicide when he was aged 37 years. There is no other known family history.

349 AS 52 years Female Negro Organic

AS complained of voices keeping her awake all night. A conspiracy between her ex-husband, her sister in law, the children of Christ, and a lady called Marie was described by AS as organised to remove her children from her care.

A positive specific serological result excluded AS from further investigation.

350 BP 56 years Female Caucasian Trial Entrant

Extremely well socially preserved Mrs P presented as a pleasant charming plump lady of Scandinavian origin. A year prior to admission she had left a job in the hospital kitchen as she felt others wished her harm. In a conversational style the patient described a mass of delusions centred upon her every movement being

watched. Mrs P felt sure that neighbours were conspiring with British Telecommunications, that the telephone was bugged and special television programmes referred to her. Even on a recent weekend away from home, she believed people in the hotel to know all about her and to be awaiting an opportunity to "play upon her nerves". She described her annoyance that people entered the house in her absence and felt her sister in law had asked them out to facilitate this. The patient had no insight. Her spouse had become worn out by the insistance of his wife in discussing the conspiracy and had with difficulty organised admission. A twenty day admission caused Mrs P to be less preocupied with her delusions, but she gained no insight. Six months after the index admission Mrs P functions at home, but has not returned to work. There is a son of the family, now living at home, who was previously an inpatient for some years in a hospital dealing with mental subnormality. His past history includes the tentative diagnosis of psychosis.

351 EB 23 years Female Caucasian Eligible

EB presented as a young woman describing her complaints in a simple style. Much of her childhood and youth was spent in care of the social services as her mother was a chronically disabled schizophrenic. EB herself was married and coped with her two small children aided by a supportive spouse.

For the past four months Mrs EB had heard voices, which commented on her every action, even when she was cleaning her teeth or using the toilet. A move of house briefly reduced these phenomena, but the voices returned, accompanied by other

hallucinations such as breathing noises which she though might come from a ghost, or her child, or perhaps her future self in the house with her. EB made reference to "the marks of Satan" but could not elaborate.

The Present State Examination placed EB within the nuclear schizophrenic category. The research interest was not pursued in view of the patient having charge of two small children and in view of the family history.

352 SN 24 years Female Negro Eligible

The most striking feature of this patient was her clumsy movements and bizarre gait, and her speech had a clipped staccato style.

She described herself as under the influence of a spirit which entirely replaced her and moved her arms and legs. This spirit seemed to SN to have power over time and to cause time to go too fast or too slowly. She believed this spirit had replaced her when she was aged eight.

The patient had lost contact with her family years ago. In view of the bizarre movements a neurological assessment was sought, but nothing was found to account for it. She remained hospitalised and grossly bizarre for six months and then suddenly absconded and could not be traced.

353 GS 23 years Male Caucasian Eligible

GS had parted from his wife and returned to his parental home

six weeks prior to admission. He was withdrawn during this period, with occasional episodes of disturbed behaviour, attempting to smash the record player, pulling a cupboard off the wall and throwing his food on the floor.

On admission, while neatly dressed, his affect was one of gross perplexity. He described in a hesitant whisper a mass of perceptual abnormalities, sounds being too loud, the television programmes in slow motion and time playing tricks upon him. He believed that others, notably his parents, had direct access to his thoughts, and felt he was experiencing telepathic communication from his wife. The patient felt quite certain that he was the subject of an experiment and under surveillance by the television, feeling that although others wished him out of the way, this conspiracy was designed to assist him. In particular he believed that paranormal forces were affecting his sexuality.

Inpatient hospital care for four months achieved limited improvement, but GS refused inpatient rehabilitation and attended a day centre after discharge. He remains slow and occasionally preoccupied with his past psychotic experiences. Eight months after the index admission he is making some progress at the day centre.

354 MFC 33 years Male Caucasian Eligible

Two years previously the patient was imbibing two bottles of whisky a day and described himself as "cracking up" around this time. He denied any psychiatric contact on this past occasion, but had been admitted on this occasion at his own request. His conversation was spattered with reference to his special

relationship with his deceased grandfather, his subconscious, astral and parapsychological themes. The only definite abnormalities were fleeting visual hallucinations of coloured shapes and some episodes of memory loss. The patient had a long history of alcohol and drug abuse and had led a life of social chaos. The present state examination placed him within the nuclear schizophrenic category. Later history revealed he had seen a psychiatrist when he "cracked up" and at his time he believed he was God, but had received no treatment the patient would disclose.

Contact was lost after discharge.

355 DMR 47 years Female Negro Not Seen

The patient was not seen for a present state examination.

356 WJ 28 years Male Negro Eligible

WJ presented as a young West Indian man wearing pinstriped trousers and waistcoat and a somewhat incongruous green plastic peaked cap. His bright social smile alternated with a flattened affect.

He had become concerned about his one year's unemployment and become convinced that others dropped hints about him. Television programmes seemed to send him special helpful messages, but also

appeared to observe him. He began to feel he had been translocated to America, also expressing the idea that he was related to the Queen and was destined to become an air pilot. These themes were freely expressed by WJ who believed paranormal forces to be at work and to be producing smells of flowers and choking unpleasant smells he had experienced. He further believed that others had access to his private thoughts, and that this would help him.

The patient remained hospitalised for six months, and then attended a day centre. His family described a two year history of deterioration, and proved most supportive when realising that WJ was unwell.

357 AA 27 years Male Caucasian Not Seen

The patient was not seen as his management was complicated by family factors.

358 RM 43 years Female Negro Deaf

The patient was profoundly deaf and it was not possible to perform a satisfactory interview.

359 JJ 25 years Male Negro Eligible

Over some days prior to admission, JJ destroyed all the furniture in his room, and the landlord's telephone. He wandered at night, scantily clad. He was afraid to go out lest others should harm him. He was not prepared to discuss this in detail, but

mentioned that Jews were implicated, and had feared for his life. He described some perceptual abnormalities of others appearing very tall, over seven feet, or unusually small.

Within a few weeks of discharge he was taken to prison. The charge was not known by the close of the study.

360 RF 33 years Male Caucasian Deaf

The patient was a deaf mute and suffered from congenital syphilis. He was excluded from further study.

361 RB 33 years Female Caucasian Unconfirmed Diagnosis on PSE

The patient had a manic illness, and a manic depressive family history. She was excluded from further study.

362 AH 21 years Female Caucasian Eligible

AH lived with her alcoholic mother and her aged grandmother. There was a long history of an abnormal premorbid personality and AH had attended child guidance. An episode of violence at home precipitated admission.

AH described herself as a special person, and hinted at a religious purpose. She described auditory and tactile communication with the Deity and believed herself to be in telepathic communication with her boyfriend. She presented as a childlike immature woman and her lack of self care and ordinary domestic skills was overwhelming. A stormy course in hospital was

characterised by her lack of insight. She continued to sporadically attend day care when the study closed.

363 TS 22 years Male Caucasian Precipitous Discharge

It transpired later this patient had had a past psychotic episode.

364 AH 18 years Female Caucasian Eligible

AH, an attractive trained singer and dancer was admitted within a few weeks of her return from a job in the Middle East. She spontaneously complained of suffering from a vitamin deficiency, but at formal interview spoke of her ability to communicate by telepathy with her mother. AH described with distress the experience of thoughts from her boyfriend in Bahrain entering her mind against her will and mentioned a voice inside her head saying 'She's got dry skin". The patient's usual high standard of self-care had deteriorated, and her mood fluctuated from depression to elation over days. The present state examination placed her within the schizophrenic category, but her mood was one of overactivity, cheerfulness and subjective competence at interview.

AH came from a disturbed background. The patient's mother was a known manic depressive, and her contact with the local psychiatric services had facilitated the admission of the patient. Her father had left home some years previously to enter a homosexual liaison, and may have had past psychiatric contact. The other child of this union was chronically institutionalised, her autistic and self

mutilating behaviour having become unmanageable at home.

AH made a rapid recovery and left for a job in the Indian subcontinent thirty-four days later. However she relapsed and returned to Britain within two months, and has been subsequently treated with Lithium salts.

365 MM 59 years Female Caucasian Previous Episodes

The patient had many psychotic episodes over some years.

366 PR 24 years Male Caucasian Eligible

The adopted son of a middle class family, PR presented with a three day history of abnormal mental phenomena. Further enquiry revealed PR to be a rather quiet youth, prone to mood swings and holding a clerical job in a solicitor's office with difficulty, having shown a steady decline in his academic and social performance from early adolescence.

On admission PR described how he had believed that obscure messages were being sent to him on television and radio and how he had felt everyone knew about his thoughts and that he might be able to influence others by his thoughts and actions. A football match that PR participated in seemed to hold the message that PR could do anything if he tried, but he also developed the belief that he had cancer and that others acted in such a way as to imply he was a homosexual.

The management of the patient was complicated by his desire to leave hospital at the least sign of improvement and the overwhelming

anxiety of his mother for total reassurance that all would be well. A brief admission of four weeks was followed three months later by attendance at the day hospital which was continuing at the close of the study. PR remained reluctant to take any medication and continued to fleetingly experience ideas of reference and thought broadcasting.

367 AB 32 years Male Negro Eligible

AB spontaneously complained that he was under the influence of the forces of good and evil. For the two days and nights prior to admission he had wandered the underground system of London, believing himself to have crossed a time warp and to have leapt through decades of time. He became convinced he could communicate by telepathy with other passengers, and believed a passenger to have telepathically conveyed to him the concept of colours having special significance. Auditory hallucinations of isolated words, "yes, no" and "you shouldn't have" appeared to come over a distance, and he also intermittently believed he had entered the world of perpetual darkness for eternity. While describing these features AB showed some insight, but remained fully deluded that God had a special mission for him.

AB was a qualified dentist, living and working successfully in London for some years. However his family organised his return to Ghana within a few days of admission. Contact was lost.

368 MQ 44 years Female Caucasian Trial Entrant

MQ lived with her two adolescent children, and her husband had a severe drinking problem, but he had always refused any intervention.

Over a few weeks MQ developed the idea that her husband had married someone else and become uncertain as to whether or not her own marriage was bigamous. She identified acquaintances as the lady or ladies concerned and became fearful for her life, believing her husband and his imaginary consort were plotting her death. She interpreted television programmes and newspaper reports as confirming her ideas.

MQ made a good recovery and gained insight, returning home within a few weeks. She persisted with depot medication for six months with the frequency of the partially held delusions of infidelity becoming less over the months. Eight months after the index admission she remained well.

369 LJ 19 years Female Negro Eligible

LJ came from a close knit family of rigid fundamentalist religious belief. She became acutely disturbed, and ran off from home. She confided that she had heard the voice of Jesus. She could not describe clearly perpetual abnormalities but was distressed by the change she saw in the world and remained suspicious of others for some days in hospital. Within three weeks she presented as a compliant pleasant girl, but remained reluctant to discuss her symptoms.

Four months later she remained well but unemployed, at home.

Her mother noted her to be even more quiet than in the past.

370 GC 50 years Female Negro Previous Episode

This elegant lady was admitted from outpatients and a fifteen year history of abnormal ideas was revealed. GC had for this time believed the whole world was bogus, that her telephone was bugged and had ideas of reference involving songs on the television. More recently she became convinced that a neighbour who was a midget was frightening her, that others entered her home in her absence, and that a plot involving the Mafia, strangers in the street and her sister in law, was organised to harm her.

As she had been admitted for three weeks elsewhere and diagnosed as depressed, but treated with trifluoperazine, some ten years previously, she was excluded from further study. However she made good steady progress, gained employment after some months, and was insightful and compliant with medication.

371 RC 23 years Male Negro Eligible

RC was transferred to psychiatric care under Section 60 of the Mental Health Act. He described the onset of his illness six months previously. At this time he experienced olfactory hallucinations, occasionally pleasant such as potato pudding, or sometimes nasty smells and the smell of dead bodies under the floor. True auditory hallucinations of isolated disconnected phrases such as "The tree of life" and "the struggle continues" were mingled with a voice that RC believed to be that of God saying "Drink some water" and

"repent". He believed that God had chosen him to organise an expedition to Africa, and had experienced visions of Christ and of other spirits that entered him and influenced his mind by telepathy. He also had partially held delusions of impending world catastrophe. RC described these phenomena with an inappropriately bland affect.

He remained an inpatient at five months when the study closed.

372 PL 22 years Male Caucasian Eligible

The patient was taken to Brixton Prison following a violent attack upon his father, who he believed to be the Devil. This event followed a few weeks when PL had become withdrawn and perplexed, making reference to religious themes. PL was from a disorganised background characterised by occupation outside legality and the history from the father of the patient was complicated by a liberal use of rhyming slang.

At interview PL described a mass of psychopathology. Abnormalities of perception were described, "Everything was very loud, I could hear the ash cracking off the end of the cigarette and hitting the floor, when I tapped the cigarette it went 'boom''boom', when I threw the cigarette on the floor it went thundering down". Isolated words and auditory hallucinations of water pouring out were present day and night, and PL described himself as holding his head a few inches off the pillow to alleviate this. He was sure he had been hypnotised by unknown persons and that this had caused him to believe his father was the Devil. Olfactory and tactile hallucinations were also present, and in particular all his food

tasted the wrong way round. PL believed he had "been crazy" and feared that he still was, and described with a measure of distress his loss of emotional response to things and people around him. He remained in hospital at four months when the study closed.

373 OD 16 years Male Negro Previous Episode

This young patient had had a psychotic episode requiring admission one year previously.

374 TG 44 yerars Female Negro Eligible

TG was admitted after protracted contact with social services. TG was initially suspicious, but became more forthcoming as the interview progressed. Her behaviour and demeanour was entirely normal, but she described herself as subject to a conspiracy stemming from work, based on the belief that a colleague at work had designs upon the gentleman who previously cohabited with TG. Over some months TG was convinced that others entered her home, and she had the locks changed repeatedly. She described how she and her children had eaten in snack bars as she was convinced her food was interfered with and how everything she cooked at home had tasted bitter. She moved her bed from room to room, finally moving it to the garage in an attempt to evade the noise of a crying baby, a noise that only she heard. Repeated experience of odd smells in the house had resulted in the liberal application of disinfectant.

The patient had lost two stone in weight during this period and had incurred considerable expense. She had no insight into the

nature of her condition. She was made redundant from her work. Hospitalisation for a month made little impression upon these fixed delusions, and shortly after discharge TG refused contact with the community nursing staff.

375 RB 16 years Female Negro Rediagnosed Clinically Not Schizophrenic

This attractive young girl came to admission after a series of domestic disputes centring around her liaison with her boyfriend. On admission she mentioned that others occasionally followed her and how she felt afraid. These ideas were fleeting and partially held.

The situation was resolved by RB going to live with her boyfriend and his mother. Four months later she was attending school and apparently normal. She remained free of medication.

376 RC 31 years Male Caucasian Treated Elsewhere

The patient was transferred to his own area after six days in hospital. A present state examination was not performed.

377 PG Unknown Female Caucasian Precipitous Discharge

The patient precipitously discharged herself before she was seen. She was readmitted just at the close of the study a month later.

378 JR 16 years Female Caucasian Rediagnosed Clinically

The clinical diagnosis was altered to personality disorder just after referral. She was not seen for a formal mental state examination.

379 HM 46 years Female Caucasian Eligible

HM presented as a plump pleasant lady, with an easy social manner. One year previously she had begun divorce proceedings, but her husband died before these plans came to fruition. These proceedings were prompted by HM developing the idea that a colleague from work had an interest in her, and that this gentleman had enlisted the aid of groups of people who observed her, and organised radio personalities who made reference to this liaison. HM described this surveillance as due to both paranormal and physical forces and believed it to be protective, but she had at times been fearful and was concerned that a carving knife was missing from her home and that she was followed by private detectives. These ideas had continued unabated despite having had no contact with the gentleman concerned for the preceding year.

HM was admitted and rapidly transferred to day care. She clung to her ideas and remained in day care at eight months until the close of the study.

380 BB 43 years Female Caucasian Unconfirmed Diagnosis on PSE

The Present State Examination placed BB within the paranoid depressive category.

501 RG 38 years Female Caucasian Previous Episodes

The patient hac suffered repeated episodes of manic depressive illness for twelve years.

502 JK 23 years Male Caucasian Eligible

A student from Greece JK was rated within the nuclear schizophrenic category by the present state examination. He transferred to private care during his admission.

503 MS 32 years Female Caucasian Unconfirmed Diagnosis on PSE

On admission the patient was overactive and disinhibited. Her manic illness was treated with Lithium and later she spent some time in the psychotherapy unit.

504 JP 33 years Male Negro (Mixed) Previous Episode

The patient was a nursing officer in a local psychiatric unit. He suffered a florid psychotic illness during which he believed he could communicate with God and that he was a reincarnation of King David, in the absence of elevated mood. He made a good recovery

..ith excellent insight, and recalled being briefly hospitalised aged 17 years for a similar but less severe illness. He remains well at 2 years and was maintained on neuroleptics for only one year.

The PSE placed him with the nuclear schizophrenic category.

505 RL 46 years Male Caucasian Organic

506 RG 56 years Male Caucasian Unconfirmed Diagnosis on PSE

This patient lost all contact with the services after his twenty-three day admission. He had depressive features which were probably associated with alcohol abuse. The PSE placed him within the depressive category.

507 PH 20 years Male Caucasian Previous Episode

Admitted under Section 60 of the Mental Health Act, PH suffered from a prolonged manic illness. Eighteen months previously he had attended a day hospital for three months.

508 WK 25 years Male Caucasian Unconfirmed Diagnosis on PSE

The patient came to London from Ireland five years ago, and held a variety of unskilled jobs, latterly working as a bus conductor for three years whilst living in digs. He became depressed and lacking in confidence and gave up work. A present state examination rated him as within the depressive category.

Treatment with antidepressants and a short course of ECT was followed by rehabilitation in a hostel while attending a day centre. Readmission at 25 months occurred, and at the close of the study the patient remained hospitalised after three months.

509 MO 22 years Female Caucasian Unconfirmed Diagnosis on PSE

Admitted under Section 136 of the Mental Health Act, MO had been wandering London in taxis. She had come to Britain to work as an au pair but this had proved unsuccessful. The PSE placed her within the neurotic category. MO returned home after nine weeks. Contact was lost.

510 FRB 24 years Male Caucasian Previous Episode

The patient had suffered several manic depressive episodes, and lived in considerable social chaos. Contact was lost immediately after discharge. He had once gained a place at medical school, and was a student of politics at the time of this admission.

511 RP 32 years Female Asian Previous Episodes

The patient gave a clear account of widespread well organised paranoid delusions. She had been treated four and fourteen years previously with neuroleptics and ECT. Hospitalisation lasted one year, and RP was discharged to a hostel.

512 SD 18 years Female Caucasian Eligible

This unemployed girl had remained in her home for some months prior to admission. The PSE placed her within the CS (catatonic schizophrenic) category. Contact was not pursued as the patient was a staff relative.

513 CC 24 years Female Caucasian Unconfirmed Diagnosis on PSE

The patient had a psychotic depressive illness and made a good recovery after two months. The patient's mother has been diagnosed as manic depressive.

514 JVP 33 years Female Negro Serious Language Difficulty

This West Indian lady spoke such accented English that it was not possible to perform a useful present state examination. It later transpired the patient had received outpatient care a year previously for a paranoid illness.

515 EG 33 years Male Caucasian Previous Episodes

The patient had received neuroleptic medication a year previously at another hospital. He had in the past had a clerical job. Fifteen months after the index admission he began sheltered employment from a hostel.

516 HD 22 years Female Negro Previous Episode

This overactive patient took her own discharge after 10 days. She had described a previous admission in Jamaica one year before. In a later admission she was given depot neuroleptics.

517 KK 36 years Male Asian Previous Episodes

The language problem proved insuperable. It later became clear the patient had received much treatment for past schizophrenic episodes.

518 LH 19 years Female Negro Unconfirmed Diagnosis on PSE

The present state examination placed the patient in the manic category. Her illness was a puerperal one. She took her discharge suddenly and then left the area.

519 GB 17 years Male Caucasian Unconfirmed Diagnosis on PSE

Throughout his index admission, the patient refused to give an account of his mental content and stood, repeatedly touching doors and counting to himself. This behaviour is combined with rituals concerning washing, eating and is overwhelmingly compelling. The diagnosis remains obscure. Intellectually he appears quite intact, but is not amenable to formal testing.

520 DL 21 years Female Negro Previous Episode

This patient had a previous puerperal illness.

521 VC 20 years Male Caucasian Previous Episode

The patient had a florid paranoid psychosis that remitted slowly. He was hospitalised for four months and maintained on depot neuroleptics. Twenty-nine months after index admission his mother reports him as well. He has taken a further A level examination and is in part-time employment.

He was excluded from the drug trial as he was hospitalised for two weeks about ten months prior to his index admission, and treated with neuroleptics. Although he lapsed from care during this time he remained psychotic until his index admission.

522 MFM 28 years Female Negro Eligible

A qualified teacher, Mrs M lived with her husband and two children. Over a few days she became restless and overactive, bathing the children at night, and fluctuating between tears, laughter and silence. She ran from the house, and this precipitated admission. She admitted to hearing the voice of God and her belief in a religious purpose to her life. She made a good recovery but remained preoccupied with religious themes.

Readmission occurred with similar episodes seven and fifteen months later. On the latter occasion recovery was more complete, Mrs M losing much of her religious overinvolvement. A clinical

diagnosis of schizoaffective disorder has been made.

523 AP 25 years Male Asian Not Admitted

The patient was seen on a home visit and described auditory hallucinations and passivity phenomena. He was maintained as an outpatient throughout.

524 EP 25 years Female Caucasian Rediagnosed Clinically Not Certainly Schizophrenic

A schoolteacher, EP described anxiety and sleep disturbance on admission. She expressed concern that another person had somehow interfered with her clothing, but acknowledged that this seemed improbable. Repeated interviews did not reveal any delusions but several bizarre overvalued ideas.

The patient left the area to stay with a sibling, and separated from her Asian spouse. Two years later she was reported to have remarried and to be entirely well.

525 WB 73 years Female Caucasian Wrong Age

526 PO 35 years Male Caucasian Previous Episodes

The patient denied any past psychiatric contact but a history from his mother revealed otherwise. Having completed an electrician's apprenticeship aged 21, the patient suffered three psychotic episodes. He had been unemployed for four months at the

index admission, his last job being that of a porter. Following discharge he attended a day centre.

527 CC 40 years Female Caucasian Previous Episodes

This patient had a previous psychotic episode hospitalisation, otherwise unspecified.

528 DP 36 years Male Caucasian Previous Episode

The patient was admitted after leaving a suicide note for his wife. He had recently been abusing alcohol and was preoccupied with religious and sexual themes. He took an early discharge and the diagnosis remained unclear. He had attended previously with similar episodes of acute behaviour disturbance, and had received neuroleptics in the past.

531 IS Unknown Female Caucasian Previous Episode

The patient never came to psychiatric admission. She had been treated some decades before puerperally with ECT.

532 RJ 24 years Female Caucasian Unconfirmed Diagnosis on PSE

This strange girl, looking much younger than her twenty-four years was transferred from a medical unit following investigation of sensory abnormalities. She was withdrawn and perplexed and described fluctuating alterations in her sense of smell and taste.

It was not possible to elicit definite delusional ideas, and the catego placed her within the manic group.

In the past the patient had worked as a copy typist, but had been unemployed for a year prior to her index admission. Thirty months later she was attending care elsewhere and maintained on depot injections. Her mother described her as grossly lacking in volition, unwilling or unable to dress herself. She had repeatedly taken overdoses of medication over the months. Her appetite had become huge, and her only interest was in cigarettes and returning to bed.

533 RB 59 years Male Caucasian Not Admitted

The patient never came to admission. He was treated with Lithium as an outpatient.

534 NG 22 years Male Negro Rediagnosed Clinically Not Schizophrenic

Referred by legal services the patient was a charming youth. He described himself as a gifted poet, and presented the staff with versions of modern poetry. The Present State Examination rated him within the possibly psychotic category, but the consensus of clinical opinion thought him to have a personality disorder.

535 AA 20 years Male Caucasian Treated Elsewhere

This youth had received initial treatment in Leeds where he was

a university student. He later came to admission in his home town.

536 KH 25 years Male Caucasian Previous Episodes

The patient had in fact had treatment on and off from the preceding four years, with periods out of care lasting several months. He had received many diagnoses, including psychotic and neurotic categories.

537 DH 72 years Female Caucasian Wrong Age

541 JP 18 years Male Negro Precipitous Discharge

A student from Nigeria, JP was admitted under Section 25 of the Mental Health Act. He returned home as soon as he was fit to travel. He was treated with depot neuroleptics and lithium salts.

542 RMC 30 years Female Caucasian Previous Episodes

This elegant Brazilian woman was medically qualified, working in Britain for postgraduate examinations. On admission she was perplexed and socially disorganised. She was unwilling to be interviewed. It later transpired the patient had received ECT for a previous episode of illness. She returned to her country of origin when improved.

543 IC 46 years Female Caucasian Previous Episodes

The patient had suffered previous psychotic episodes unspecified.

546 DL 44 years Male Caucasian Unconfirmed Diagnosis on PSE

The patient was admitted under Section 25 of the Mental Health Act following aggressive behaviour at home. Some five months previously he had been released from prison having served a sentence for bodily harm and assault. He was preoccupied with themes of violence, karate and judo and was grossly overactive and elated. The Present State Examination placed him within the manic category. Detention under Section 26 of the Mental Health Act became necessary, and he was discharged after twelve months, much improved.

547 AR 30 years Female Caucasian Serious Language Difficulty

Dishevelled and nonco-operative on admission the patient continued to be almost silent during her admission. A present state examination was not possible, but the patient was readmitted three months later in a similar state. Eventually sixteen months after the index admission treatment with oral neuroleptics was begun, the patient being subject to Section 25 of the Mental Health Act.

548 AF 24 years Male Moroccan Serious Language Difficulty

Living in a student hostel this Moroccan youth behaved very

oddly, and came to admission under Section 136 of the Mental Health Act. He was overactive, wandering the ward dressed in traditional Moroccan gowns. His English was very limited, but he described his power to translocate the mosque in Hyde Park to his home town. He was repatriated.

550 JW 24 years Male Caucasian Unconfirmed Diagnosis on PSE

This sullen youth was living with his wife and two infants, and referred himself to psychiatric care. His complaints centred around somatic and psychic anxiety. He had a past history of contact with the police and minor drug abuse. He consistently refused to reduce his excessive alcohol intake, and attended day care sporadically.

551 KS 28 years Female Asian Precipitous Discharge

The patient discharged herself precipitously and was not seen by the research team. She had no further contact with her base hospital in the ensuing two years.

553 FEC 33 years Male Caucasian Previous Episodes

The patient was rated within the P+ category on the PSE but had suffered previous episodes of psychosis over eight years, including periods of apparent remission.

554 AS 20 years Male Caucasian Previous Episodes

AS described his parents as imposters and himself subject to the influence of black magic practised upon him by a group of popular singers. Language problems precluded a full interview.

The patient had had an admission, elsewhere, two years previously.

555 SJ 28 years Female Negro Previous Episode

The patient had had an episode of psychosis three years ago.

556 DT 19 yrs Female Caucasian Previous Episode

The patient was referred after relapse, having been discharged for two months.

557 SN 19 years Male Negro Unconfirmed Diagnosis on PSE

The Present State Examination did not place the patient within a psychotic category.

558 YJ 21 years Female Negro Unconfirmed Diagnosis on PSE

The present state examination did not place YJ within the psychotic category.

559 PO 21 years Male Caucasian Patient Refused Interview

The consultant in charge of the case asked the research team not to visit.

560 CJ 34 years Male Caucasian Previous Episode

Bizarrely dressed in a cowboy hat and coloured shirt, this patient expressed vaguely his belief in his special purpose and described true hallucinatory voices. He was currently unemployed but had once trained and worked for several years as a technical illustrator. Five years previously he had attended a day hospital for three months with a diagnosis of schizophrenia. He was discharged after fifteen months to a hostel and to day care attendance.

561 PS 33 years Female Caucasian Eligible

Examination did not reveal clearly described psychiatric abnormalities, although the patient had an unusual way of expressing herself and many ideas suggestive of psychosis. The patient had had many past contacts with fringe services and constantly used odd spiritualistic terminology. However PS was placed within the psychotic category on PSE.

PS remained hospitalised in a psychotherapeutic setting for two years.

562 FF 60 years Female Caucasian Precipitous Discharge

Admission for a paranoid psychotic illness was brought to a close after ten days by this retired lady. She was not seen by the research team, but attended follow-up for over one year at her base hospital, with continuing symptoms.

563 JM 26 years Male Negro Precipitous Discharge

The patient took his discharge precipitously and was not seen.

564 VA 21 years Female Asian Previous Episode

The patient was in full time secretarial work until a few days prior to her admission under Section 29 of the Mental Health Act. Nine months previously she had suffered a psychotic illness, and she transferred her care privately on this admission.

565 RA 32 years Female Asian Precipitous Discharge

The patient left hospital precipitously but came to a prolonged admission, for one year, later. She was diagnosed as manic depressive, treated with neuroleptics and ECT. She worked as a typist before and after the illness, and went abroad only to relapse and be admitted to her base hospital once more. She was excluded from the study originally on the basis of her rapid self discharge.

566 AD 21 years Female Asian Previous Episode

At interview AD described herself as fearful of her family, particularly her sister-in-law, thinking they were poisoning her. A well organised paranoid network was revealed. The patient had been hospitalised a year previously with a similar illness which was not thought to be clearly psychotic at that time, although the diagnosis of schizophrenia was tentatively raised.

567 BG 34 years Female Negro Not Seen

This woman was separated from her spouse and her eight year old child was in foster care. She was admitted for three days only, following an episode of self harm. Contact was lost. Although the patient stayed for a few days with her mother a year later, she has not been heard of since.

568 AP 35 years Male Asian Previous Episode

A twenty four day admission was followed by admissions lasting four and seven days occurring six months and one year later. The patient had been admitted previously elsewhere, and thought to be an alcoholic at this time.

569 WH 17 years Male Caucasian Precipitous Discharge

Working as a council gardener this youth only remained in hospital for seven days. He was treated with antidepressants which

were stopped at discharge.

570 JJ 36 years Female Caucasian Previous Episodes

A domestic worker in her base hospital the patient suffered from religious delusions. She had many past admissions and was maintained, with her intermittent co-operation, on depot neuroleptics.

571 MW 21 years Female Caucasian Previous Episodes

At admission this Scottish girl gave a false name, but was clearly psychotic. Transfer to her previous hospital where she had been treated for several schizophrenic illnesses over three years was arranged.

572 AO 33 years Female Mixed Eligible

A qualified nurse, AO had recently holidayed in Tahiti. She became elevated in mood, gave away many belongings, and sang hymns ecstatically, day and night. She believed God intended her to be a missionary.

The patient had been involved in a fundamentalist faith for many years. She described features suggestive of schizophrenia and was rated within the psychotic category.

However contact was lost at discharge.

573 MA 36 years Male Caucasian Previous Episode

This patient had had a previous episode of psychosis.

574 DV 40 years Male Asian Serious Language Difficulty

The patient spoke no English but was diagnosed as schizophrenic by the consultant psychiatrist who spoke the patient's language. A two month admission was followed by day care attendance, and the patient was maintained on depot neuroleptics.

575 QF 23 years Female Asian Unconfirmed Diagnosis on PSE

A Present State Examination placed this young woman in the manic category. A two week admission was rapidly following by a five week one, but the patient returned to her jobs as a dressmaker and office work. Poor renal function precluded maintenance Lithium but the patient remained well.

576 DT 40s Female Caucasian Unconfirmed Diagnosis on PSE

The patient was diagnosed as manic depressive.

577 AA 24 years Male Not known Previous Episode

The patient soon revealed a previous episode of psychosis.

578 WH Male Precipitous Discharge

The patient took his discharge after 72 hours.

582 CAD 34 years Female Caucasian Previous Episode

A previous episode excluded this unemployed woman from the study.

583 RQ 24 years Male Caucasian Previous Episode

The patient had suffered from a past psychotic illness and was thus not seen.

584 PN 24 years Female Negro Precipitous Discharge

Admitted under Section 25 of the Mental Health Act, the patient none the less absconded after five days and could not be traced.

585 SA 47 years Female Asian Serious Language Difficulty

A serious language difficulty made a Present State Examination impossible. This woman rapidly developed a spontaneous involuntary movement disorder and was hospitalised for ten months during the latter half of 1980 and during 1981.

586 MP 22 years Female Caucasian Previous Discharge

A past episode of psychosis precluded the patient from further study.

587 MD 17 years Male Caucasian Unconfirmed Diagnosis on PSE

This schoolboy had a passionate interest in chess and won several competitions. He became increasingly overactive and developed grandiose ideas concerned largely with his ability at chess. The Present State Examination placed him with the manic category. He was maintained on Lithium carbonate as an outpatient.

588 JJW 21 years Male Caucasian Precipitous Discharge

This youth's admission lasted only eight hours. He absconded and then left the area.

589 DQ 40 years Female Caucasian Eligible

This lady from Singapore was briefly admitted under Section 136 of the Mental Health Act, and promptly readmitted to another unit. She described a widespread delusion network, believing God had made her pregnant with twins and had singled her out to avert a world wide catastrophe. Lucifer, archangels and the Deity communicated with her, these auditory hallucinations being constantly present. The overactivity and grandiose quality of DQ's mental state was overwhelming.

After two months inpatient and day patient care DQ returned to Singapore.

591 MH 31 years Male Asian Previous Episode

A warehouseman, MHG was first admitted for three months in 1980. However he had received a diagnosis of schizophrenia (but no treatment) eleven years previously, and had attended outpatients both two and one year previously. Fifteen months after his discharge he remained well and maintained on depot neuroleptics.

592 NB 23 years Female Asian Precipitous Discharge

The spouse of the patient removed NB from care after three days. There was no further contact.

593 HM 31 years Male Caucasian Previous Episode

One of a pair of identical twins, HM initially insisted that he had never been admitted to hospital before, and later claimed his past admission to be due to mistaken identity. The patient's twin was a known chronically unwell schizophrenic but HM had indeed suffered a psychotic illness in the past, and at that admission had been thought to be his brother, until the brother visited him.

After discharge he attended a day centre for over one year.

595 SR 23 years Female Caucasian Unconfirmed Diagnosis on PSE

The Present State Examination placed SR in the manic category.

596 BH 29 years Female Caucasian Previous Episode

Hospitalisation for three months preceded the index admission by one and a half years.

597 AN 55 years Male Caucasian Unconfirmed Diagnosis on PSE

The Present State Examination placed the patient in the manic category. After a brief admission all contact was lost.

598 BM 45 years Male Caucasian Organic

There was an organic component to the paranoid illness the patient suffered.

599 AM 30 years Male Negro Precipitous Discharge

Due to precipitous self discharge the patient was not seen for a present state examination. He later came to a protracted readmission and was treated with depot neuroleptics. After nine months he was discharged to a hostel.

600 KC 17 years Male Caucasian Treated Elsewhere

KC had been attending an adolescent unit when his behaviour dramatically deteriorated. On admission to the local large mental hospital he was grossly overactive and disruptive. KC was moved between these two services, but eventually was admitted under Section 25 of the Mental Health Act and later treated with depot neuroleptics.

In view of the complications of shared care he was not fully assessed.

601 DM 19 years Female Negro Precipitous Discharge

The patient took her own discharge before she could be assessed. Contact was lost.

602 DB 32 years Male Caucasian Previous Episode

Despite an admission lasting seven months the patient absconded and all contact lost. He had previously attended as an outpatient elsewhere, receiving an affective diagnosis, but had also been treated for paranoid schizophrenia five years and one year prior to the index admission. These contacts had similarly been abruptly ended by the patient.

603 RC 26 years Male Caucasian Previous Episode

Of continental origin, RC was admitted for six months with a diagnosis of schizophrenia. A year previously he had been hospitalised for psychotic illness while in Mexico City. A maternal aunt and a brother had had schizophrenic illness of some severity, and a sister was well known to local services for repeated episodes of self harm.

608 BM 33 years Female Caucasian Organic

The patient had an organic basis to her illness.

609 JP 32 years Female Asian Previous Episode

The patient has suffered a psychotic illness in the past.

610 JG 21 years Female Asian Unconfirmed Diagnosis on PSE

This thin Asian girl described herself as "ticking away a bit faster", feeling healthy, full of energy and having a very good future. She spoke freely with a strong Manchester accent but had some difficulty in comprehending the questions. The Present State Examination placed her within the manic category. Contact was lost within a month of discharge.

611 MLD 40 years Female Caucasian Rediagnosed Clinically Not Certainly Schizophrenic

A three year history of neurotic illness related to her spouse's drug charges and the patient's own excessive alcohol intake preceded this admission. On admission the patient was very unkempt and dishevelled, had no spontaneous conversation, and it was not possible to ascertain fully her mental content. The patient's behaviour became increasingly importuning, and she expressed the idea that others could read her mind and complained of derogatory auditory hallucinations. Treatment with both ECT and neuroleptics brought about a slow halting change, the patient becoming more communicative and maintaining some self care. She remained rather facile with noticeable posturing, but was maintained functioning at much below her premorbid level outside hospital for the following year. A diagnosis of psychosis not otherwise specified was made.

612 MS 21 years Female Caucasian (Cypriot) Unconfirmed Diagnosis on PSE

This pretty girl described a mass of fears and anxieties related to a broken love affair. An overdose precipitated admission. It was not possible to elicit any signs of psychosis, although the patient continued to express hopelessness and loss of interest. There was a family history suggestive of manic depressive illness.

613 CJS 21 Female Negro Precipitous Discharge

Within two days this patient absconded and hence was not assessed. However she attended outpatients and was subsequently maintained on depot neuroleptics, remaining out of hospital for the following year.

614 KK 43 years Male Asian Eligible

Language difficulties precluded further assessment of this part time porter. He lost contact with the hospital after his brief admission, in which he was undoubtedly psychotic.

615 DB 16 years Male Negro Previous Episodes

Despite the patient's youth he had received treatment in America for a psychotic episode one year previously.

616 JG 31 years Female Caucasian Previous Episodes

The sister of a manic depressive patient, JG had had two episodes of a paranoid delusional illness, but was well between episodes and maintained on very low doses of neuroleptics. This relapse followed withdrawal from medication.

617 RG 23 years Male Asian Previous Episodes

Although this was the patient's first admission to the base

hospital he had received treatment with neuroleptics and ECT in both Britain and India in the past.

618 AAK 22 years Male Caucasian Clinician Requested no Interview

An unemployed arts graduate, AAK received treatment as an inpatient and day patient for over a year. He was involved in another research project and hence not seen.

620 OL 23 years Male Caucasian Clinician Requested no Interview

Whilst an undergraduate this youth developed a schizophrenic illness. His management was complicated by family factors and he was not assessed at the consultants' request.

621 JG 26 years Male Caucasian Treated Elsewhere

After graduating the patient left Scotland to seek work. He was hospitalised, acutely disturbed and hallucinated, after sitting on a roof in a disorganised style. Within the week he was transferred at his family's request, and received four months inpatient care, with a diagnosis of schizophrenia. Ten months after the index admission he is well, seeking work, and on no medication.

622 PW 14 years Male Caucasian Wrong Age

This schoolboy remained in hospital for fourteen months until the entry of the study closed. He was initially excluded because of

his youth.

623 SGG 32 years Female Caucasian Previous Episode

The patient had a previous episode of psychosis, unspecified.

624 BH 31 years Male Asian Previous Episode

The patient had at least one episode of psychosis.

625 JC 38 years Female Caucasian Previous Episode

JC was admitted for three days, diagnosed as psychotic and treated with neuroleptics. One year later readmission under Section 26 of the Mental Health Act occurred. After some months JC attended a day centre, and is now maintained on depot neuroleptics.

She described another previous episode two years prior to the index admission, following upon the breakdown of her marriage.

The patient's mother is a chronically disturbed hospitalised schizophrenic.

626 AE 17 years Male Caucasian Unconfirmed Diagnosis on PSE

A schoolboy, AE was treated with lithium and neuroleptics, receiving a diagnosis of manic depressive illness.

627 GM 34 years Female Asian Serious Language Difficulty

This Asian housewife took her discharge after six days and contact was lost. Six months later readmission followed an episode of self harm. The patient had sustained fractures to both calcaneii. She appeared physically well but remained psychotic. Sudden death caused by bilateral pulmonary emboli occurred eleven days later. The Coroner returned a verdict of accidental death.

629 CW 37 years Female Negro Previous Episode

The patient had previously been admitted for a psychotic illness in Jamaica.

630 MS 29 years Male Caucasian Previous Episode

MS lived with his grandmother and he had never been employed. Admitted after creating a disturbance he described himself as certain that a telescope was due to be delivered to him from the police, and became angry if challenged on this theme. He had had a past admission to a mental subnormality hospital thirteen years previously when the question of psychosis was raised.

His mother had been institutionalised since his birth, and had died in a mental hospital.

Full Details of the 15 'Organic' Cases

1) Pt 060

Mrs AJ 53 years PSE Classification DS Schizophrenia

Personal History

Born 1927.

Of Irish extraction, the daughter of a farm caretaker.

Left school aged 14.

Employed in factory and machine operating work until 1978.

Married aged 29. No children. Separated in 1962.

No contact with family.

Smoked 30/day since age of 8 years, chronic bronchitis since 1960s.

Psychiatric details

Admitted following self referral January 1980

c/o Afraid to leave home, neighbours plotting against her.

Mental State

Floridly paranoid, with auditory hallucinations of tapping, screaming "What is she doing now". Had acted upon delusions and hallucinations for some weeks, and made complaints to housing officials, been afraid to run water in her home for fear of betraying her exact whereabouts. Co-operative, orientated, with warm affect and no insight, seeking admission on grounds of safety.

Progress

Never relinguished delusions although these did not generalise to include hospital environment. Repeated chest injections, but refused to stop smoking. Refused to return home, repeated attempts unsuccessful. Transferred for longer term care and hopefully rehabilitation. November 81 - weakness in L hand and both legs. Transferred for investigations to another centre.

Investigations

Chest X Ray	7cm x 8cm mass L upper zone
Bronchoscopy	Squamous cell carcinoma
CAT Scan	Right parietal and frontal cerebral infarction.

Diagnosis

Squamous carcinoma L lung

Cerebral infarction

Chest infection

? Paranoid schizophrenia

Mrs AJ was gravely ill at the close of the study. The relationship between the initial presentation, the final diagnosis and the lack of response to neuroleptic medication remains open to question.

2) Pt 153

Mrs SB 28 yrs PSE classification NS Nuclear Schizophrenia

Personal History

Born 1952

University graduate, employed in merchant banking at high level of responsibility. Married aged 22, spouse a design engineer. No children.

Psychiatric details

Tentative diagnosis of schizophrenia made in another medical centre (vide infra).

Admitted 1980 at request of spouse and the medical centre.

c/o No spontaneous complaints.

Mental state

Grossly personally deteriorated with inappropriate behaviour. Affect distant, speech hesitant and vague with obviously wide vocabulary. Described illformed auditory hallucinations and belief that she was influenced by spirits living in attic of house. Mild disorientation noted.

Medical history

1960 - 1970 Joint pains

1970 Cardiac enlargement noted at screening as undergraduate

1974 Cardiac enlargement persisting and investigated :

no cause found

1974 Erythematous eruption on arms

1979 Cardiac enlargement more severe

Acute pericarditis: biopsy suggestive of immune complex disease

Pericardial resection

First psychiatric contact ? Schizophrenic

1980 Discharge home and admitted to local medical centre

Transferred for further investigation.

Investigations

Old Choreoretinitis both eyes

CAT scans display cortical atrophy when youth of patient considered: repeated: apparently worsening, with ventricular enlargement.

Diagnosis

Clinical presentation consistent with generalised autoimmune disease, supported by some haemological testing. Diagnosis of systemic lupus erythematosus not supported by biochemical testing.

Energetic treatment with an immunosuppressive regime did not alter Mrs SB's condition. The patient, at the close of the study, continued to deteriorate in chronic care, and developed contractures and became mute.

The father of the patient suffered from retinitis pigmentosa,

and a more distant relative was thought to be similarly affected.

3. Pt 176

Miss JN. 40 years PSE Classification NS Nuclear Schizophrenia

Personal History

Born 1940.

Single mother of four illegitimate children.

Unemployed.

No other personal details bar some family history: mother received psychiatric inpatient treatment for some months (no other details)

Psychiatric details

Admitted at request of social worker, concerned over patient's mental state.

c/o Having burnt all her clothes and shoes because she thought she had cancer.

Mental state

Garrulous lady, talking freely, Describes having the thoughts of others enter her head, and being compelled to act upon these ideas, and a mass of complex ideas of reference concerning odours, death and exorcism. Attributed these events to the supernatural power of an unnamed religious body attempting to assist her. Dates onset of this as following a recent termination of pregnancy.

Medical history

1970 Complaints of tiredness, lethargy, breathlessness

CXR diagnosis Pulmonary Sarcoidosis

No treatment

1971 ESR remains slightly elevated CXR unchanged

1977 Skin rash

Diagnosis Guttak psoriasis

Thought to be unconnected with sarcoidosis.

1977 Complaint of poor vision

No abnormality at assessment

Negative Mantoux test

Kviem's test not recorded

1980 CXR Hilar enlargement consistent with sarcoidosis

ESR 11 mm/1 hr

Diagnosis

Schizophrenia

Sarcoidosis

The relationship between sarcoidosis and the mental state of the patient is far from clear. Miss JN spent fifteen of the following seventeen months in day or inpatient care.

5. Pt 216

Mrs RC 36 years PSE Classification NS Nuclear Schizophrenia

Personal history

Born 1945.

Brought up in Ireland

Married Anglo-Indian man, when aged 25. Believed spouse to be Italian, divorced him in 1976 when she realised his racial origin. However, moved from London with ex-spouse and child in 1978. Spouse died in 1979, leaving her to care for five year old son.

Employed in data processing until birth of son.

Psychiatric details

Admitted to day care 1981 January.

c/o Persecution by neighbours.

Mental state

Anxious woman, describing the unhelpful attitude of others and attributed abusive auditory hallucinations to her neighbours, commenting on her every action, and believes others to be in telepathic communication with her. Dates these ideas as beginning in 1974, when she took an overdose.

Medical history

1972 Chest pain, malaise, cough

CXR bilateral hilar enlargement

Bronchoscopy : biopsy confirms diagnosis of sarcoidosis

No treatment: under review.

1974 Delivery of healthy male child

1974 8 months post partum, overdose of librium.

Notes record bizarre account of marital difficulties.

Also generalised rash recorded. No investigations.

Patient seeks divorce.

1975 CXR Hilar Enlargement unchanged

Blood stained sputum. ESR 26mm/1 hr

1976 Defaults from review at Chest Clinic

Divorce obtained, but close contact with spouse

1978 Ex spouse, patient and child move from London

1979 Spouse dies

1981 Admission to psychiatric care

CXR hilar enlargement unchanged.

Diagnosis

Schizophrenia and sarcoidosis. The patient made a poor response to neuroleptic drugs and received eight months of day care, remaining in outpatient attendance for a further four months, when contact ceased. The relationship between childbirth, the psychotic features and the sarcoidosis remains unclear.

6. Pt 231

Mr WB 33 years PSE Classification NS Nuclear Schizophrenia

Personal history

Born 1947.

Unemployed, of no fixed abode

Last employment as a road sweeper

Past record of offences (house breaking/assault)

aged 15,16,18,21,33.

Registered drug addict aged 17 and aged 29

Abused: benzodiazepines/barbiturates/heroine/morphine/

physeptone

Family history

Father died of cirrhosis of liver due to alcohol abuse

3 siblings alive and well

Psychiatric details

Transferred from judicial services under Section 60 of the Mental Health Act

c/o "Silicon chip in stomach controlling my brain"

Mental state

Tattoo-marked young man, expressing a mass of somatic delusions and describing auditory hallucinations.

Diagnosis

Schizophrenia associated with long term drug abuse.

The patient made a poor response to neuroleptics, and demanded other forms of medication. A five month admission was followed by two brief admissions under Section 136 of the Mental Health Act, and the patient was again hospitalised at the close of the study.

7. Pt 247

Mrs RS 33 years PSE Classification None

Personal history

Born 1947.

Medical practitioner, born and brought up in India.

Spouse an architect, successful marriage.

Family history of epilepsy.

Psychiatric details

Admitted 4 days postpartum in distress.

c/o Tearful, distressed, unable to convey clear complaints.

Mental state

Perplexed, tearful young woman with incoherence of speech and delusional mood. Believed other mothers made indirect suggestions to her, and that questions and noises had special meanings. Described hearing voices repeating the questions of the interviewer. Orientated in time, place and person but mental state fluctuated over hours and days.

Past history

Aged 18 Nocturnal convulsion : normal EEG

Diagnosis idiopathic epilepsy. Treatment phenobarbitone for three years. Reactive depression over love affair but had auditory hallucinations and believed father was dying.

Aged 23 Fleeting visual misperceptions : stars and dots
One tonic clonic convulsion: recommenced phenobarbitone.
Persistent intermittent eyelid twitching
Simultaneous depressive features with fears for health of family (groundless)

Aged 29 Eyelid flickering progressing to cold numbness on right side of face with twisting of right side of body, lasting two minutes or less in clear consciousness.
Further tonic clonic convulsion
Admission and CT scan in America
Diagnosis Cerebral Cysticercosis
Confirmed in UK
Treatment phenobarbitone

Aged 30 Two months of fluctuating mental state with auditory hallucinations, incoherent speech and bizarre behaviour (once tried to leave aeroplane during a flight).
Spontaneous resolution.

Progress

Resolution of mental state over two weeks, with benzodiazepines in addition to continuation of phenobarbitone. Referral to Neurological Centre for assessment.

Diagnosis

1) Multifocal epilepsy due to cerebral cysticercosis with tonic/clonic and simple parietal seizures. Thought to have active

focus in occipital lobe and possibly on the medial hemispheric surface involving the supplementary motor area.

2) Recurrent psychotic episodes secondary to the above.

8. Pt 274

Mr MO'C 38 years PSE Classification S+ Definite Schizophrenia

Personal history

Born 1942.

Unmarried Irish labourer of no fixed abode

Frequently unemployed

Many convictions for petty offences, usually theft of alcohol

Excessive alcohol intake from age 18 years

Psychiatric details

Stopped all alcohol 48 hours prior to admission. Became auditorily hallucinated, hearing "We're going to get you", and believed cars to be following him. Cut his wrists in lavatory of public house and was admitted to medical care, requiring transfusion. All the symptoms remitted and he was discharged at seven days. Extreme alcohol intake over the next three days resulted in return of psychotic features, patient requested admission.

Mental state

Pleasant middle aged Irishman, freely proferring history of excessive alcohol intake. Described auditory hallucinations as above, and saying "He's 20 miles from Gerrards Cross, he's gone this way" and music of a popular song coming from his head, with a mass of ideas of reference.

Progress

Contact was lost after a three week admission, when all symptoms had remitted.

Diagnosis

Paranoid psychosis on withdrawal and on re-exposure to alcohol.

9. Pt 287

Mrs MA 54 years PSE Classification D+ Depressive Psychosis

Personal history

Born 1926.

Married housewife of Irish extraction.

No children, modest domestic circumstances

Psychiatric details

Admitted at request of general practitioner May 1981.

c/o Cars following her, flashing lights from neighbours as signals.

Feet running over the roof nightly.

Mental state

Suspicious at interview but described a neighbour in the garden holding an African spear, and of notes and pork pies left in the garden deliberately. On enquiry Mrs MA described auditory hallucinations and attributed the above to a conspiracy of traffic wardens, police, space agents and soldiers in the medical professions, all organised by witchcraft.

Progress and investigation

Serology VDR positive negative in CSF

TPHA positive

Treated with neuroleptics and penicillin, with fair response and early appearance of spontaneous involuntary movement disorder. Later revealed history of premarital affairs and an illegitimate

pregnancy (unknown to spouse).

Aug 81 Loss of consciousness and aura

EEG revealed left temporal focus

CT scan: normal.

Diagnosis

Syphilis

Paranoid psychosis

Epilepsy

10. Pt 292

Miss SU 29 years PSE Classification ?DP ?AP Depressive Psychosis

Personal history

Born 1952.

Single unemployed daughter of Kenyan Asian business family.

6th of 9 daughters. Very limited English.

Normal infancy; performance at school poor aged 10.

Treated with thyroxine aged 12, no known investigations but one sister also treated with thyroxine for cretinism.

No education after age of 12.

Family came to UK 1975.

Psychiatric details

Admitted May 1981 : history obtained from patient and family c/o Increasing irritability, with destructive violence and social withdrawal. Ceased domestic help in the home and constantly expressed fixed belief that her parents were imposters (capgras syndrome).

Medical details

On admission normal physique but with goitre

Taking 200 mg/day Thyroxine

Investigations Thyroxine 160-178mmol/l

T_3 uptake 89-91

T_4/T_3 index 1.80-1.96

Triodothyroxine 3.3-3.7

Thyroid scan: autonomously functioning nodular thyroid gland.

Thyroxine dosage reduced to 150 ng/day.

Progress

Repeated brief admissions over coming year. Mental state and presentation increasingly suggestive of depressive psychosis.

Diagnosis

Depressive psychosis

Thyroid dysfunction

? Mental retardation induced by thyroid dysfunction.

The relationship between these three factors remains unclear.

11. Pt 328

Mr NS 17 years PSE Classification NS Nuclear Schizophrenia

Personal history

Born 1964.

Unemployed only son of indulgent parents.

Normal childhood and development.

Sociable, outgoing, slightly "eccentric"

Psychiatric details

Transferred from police custody. On admission handsome disorganised youth, speaking of organising coaches to take the entire population to a festival in Aberystwyth and being under the direct influence of God. He described a mass of perceptual abnormalities, time having advanced, and described a computer called "trivia" reading and broadcasting his thoughts. Gave history of extensive drug ingestion, initially thought by the author to be delusional.

Drug history (confirmed by friend of patient)

Has taken heroin, amphetamine, cocaine, barbiturates, cannabis, LSD, psylocybin. Preceding admission within 24 hours had ingested: 1/4 gm Persian heroin, 1 gm amphetamine sulphate, 7 LSD dosages.

Progress

Fluctuating but persisting symptoms for first month, but abusing drugs whilst on pass. Repeated brief admissions for two

months, with complete resolution of symptoms.

Diagnosis

Drug induced psychosis.

12. Pt 349

Mrs AS 52 years PSE Classification S+ Definite Schizophrenia

Personal history

Born 1929.

Lives with two daughters. No other details.

Psychiatric details

Admitted under Section 29 of the Mental Health Act. Initially extremely evasive, but described herself as subject to persecution by the Children of Christ, organised by her sister in law and estranged spouse. Voices talking about her kept her awake all night, and she had poured large quantities of bleach down the sink to destroy the unusual smell. She described herself as being hypnotised by "Marie" and believed all of the above to be designed to force her to leave the house.

Investigations VDRL Positive

TPHA Positive No other details

Progress

Took early discharge at 39 days and lapsed from outpatient attendance two months later.

Diagnosis

Paranoid psychosis

Syphilis

13. Pt 505

Mr RL 46 years PSE Classification DP? P? R+ Residual Schizophrenia?

Personal history

Born 1935.

Publican of large hostelry for four years

Worked in catering since National Service

Married aged 24, no children

"Enjoys a drink". Takes spirits daily.

Psychiatric details

c/o Admitted under Section 25 of the Mental Health Act. Suddenly becoming afraid he was to be killed, and made superficial lacerations of throat in response to this. Violent on admission, convinced hospital staff part of a conspiracy. Tremor, sweating, sleep disturbance but no auditory hallucinations.

No investigations available.

Rapid resolution of symptoms over one week. Total episode 2/52 duration.

Diagnosis

Presumptive diagnosis of alcohol related paranoid illness.

Later revealed similar brief admission four months previously, and came to readmission one year later.

14. Pt 598

Mr BMcG 45 years PSE Classification DP P? Paranoid Psychosis

Personal history

Born 1936.

Unemployed married man of Irish extraction

Moderately deaf

Family history of alcohol abuse

Alcohol history

Drinking since aged 14

10-12 pints of beer and 10-12 measures of spirits a day from 14-24 years

Thereafter 5 pints of beer a day

Police contact 1971 - drink related.

Psychiatric details

Admitted for assessment at request of family doctors.

c/o Nausea, malaise, headaches.

Wakes feeling animals about to bite him.

Increasing suspicion of others over many years, but described feeling over the preceding month that people at the church do not want him, that the hospital will investigate his social security benefits, and that others pass hints to him and mimic him. The patient also expressed ill defined ideas of bodily and sexual change; feeling parts of his body shifting.

Investigations

MCV elevated at 107.

Liver function tests abnormal.

Progress

Two month admission with improvement

Diagnosis

Alcohol related psychosis.

15. Pt 608

Miss BM 33 years No PSE

Admitted in a disturbed state, the patient had fallen from a window one year previously and sustained a serious head injury. The resulting hemiparesis had not resolved. Further enquiry revealed a history of overdosage and excessive alcohol intake with treatment in Australia.

Diagnosis

Head injury and hemiparesis.

Behavioural disturbance.